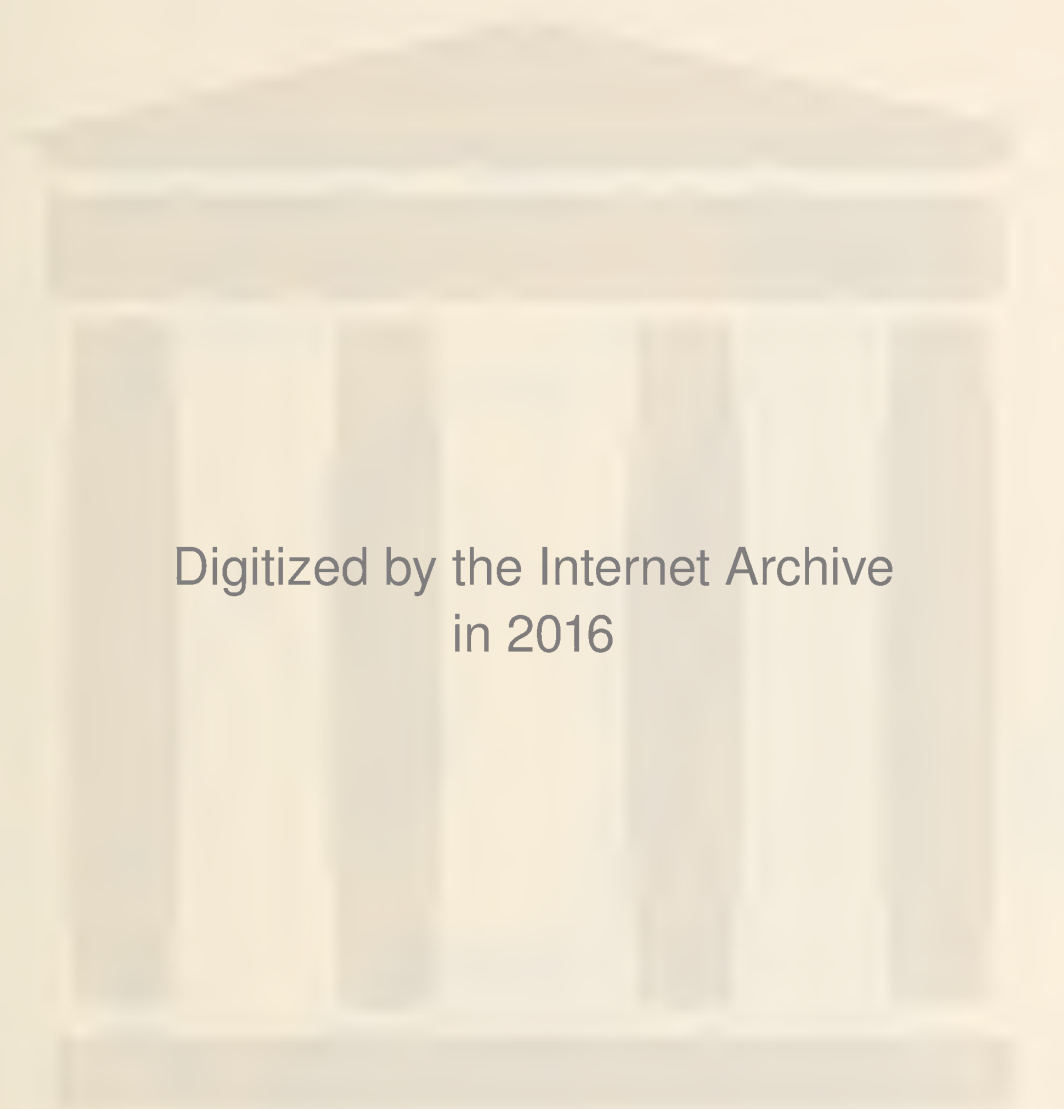




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JULY 1986



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# JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

JULY 1986

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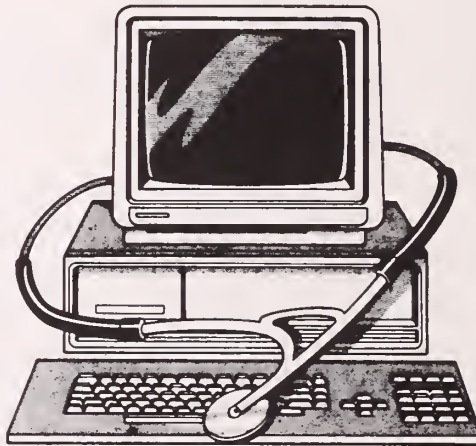
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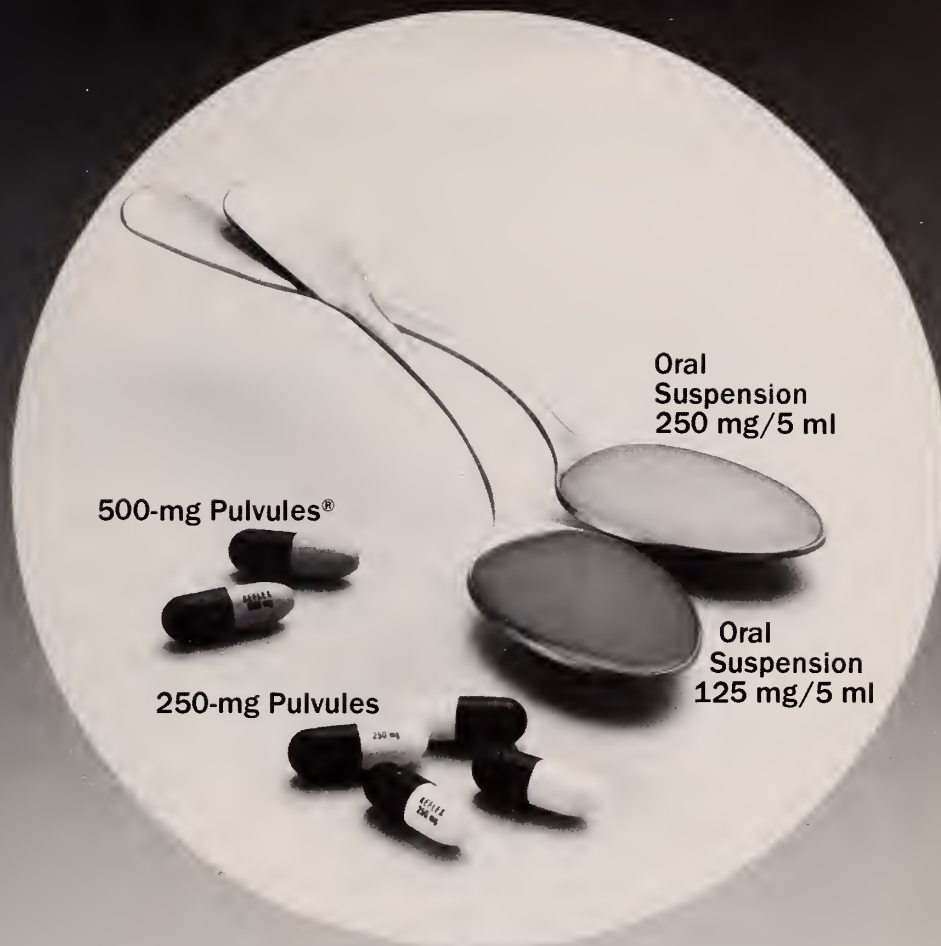
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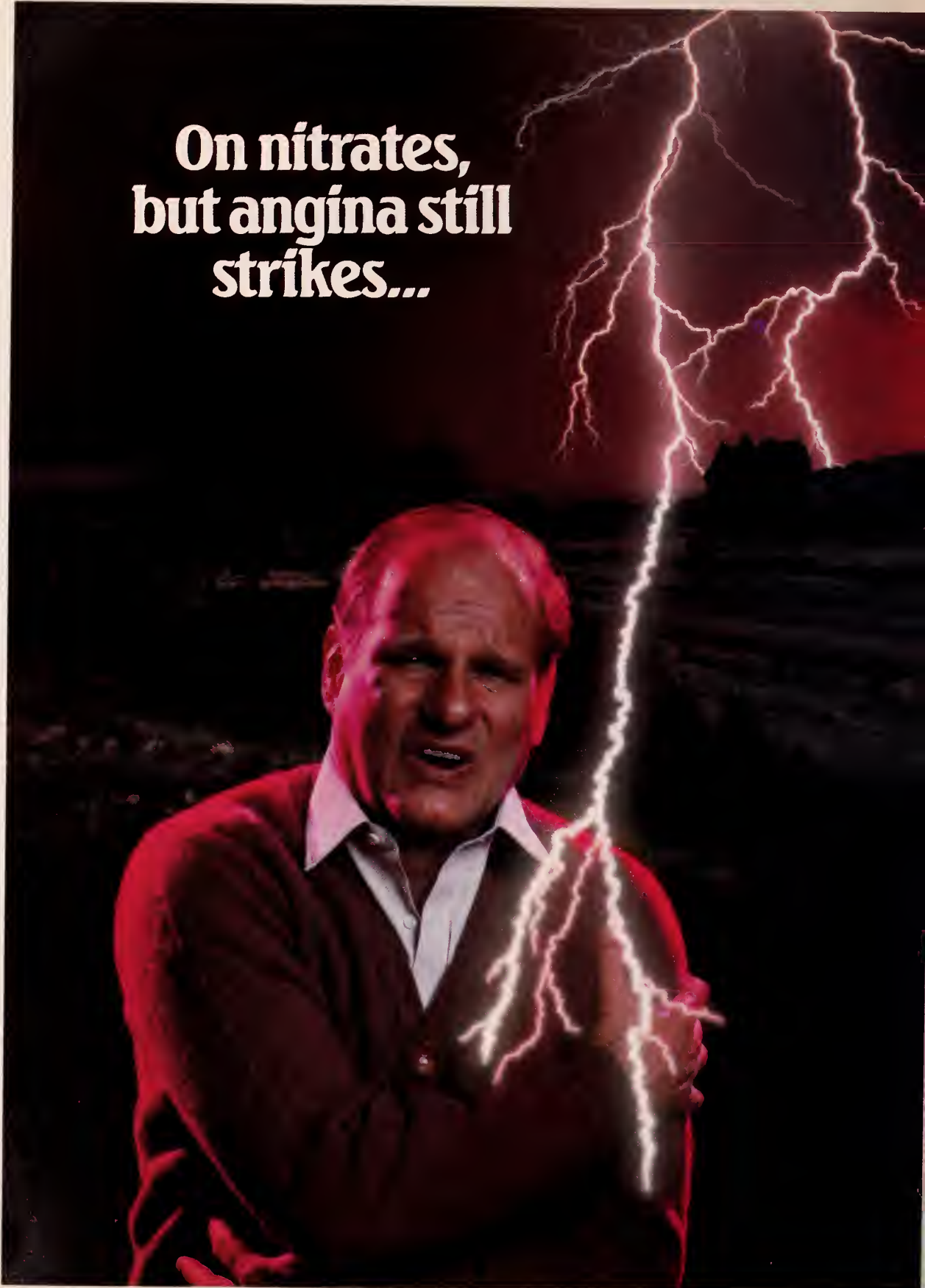
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Elevations of transaminases with and without concomitant elevations in alkaline phosphatase and bilirubin have been reported. Such elevations may disappear even with continued treatment, however, four cases of hepatocellular injury by verapamil have been proven by rechallenge. Periodic monitoring of liver function is prudent during verapamil therapy. Patients with atrial flutter or fibrillation and an accessory AV pathway (e.g. W-P-W or L-G-L syndromes) may develop increased antegrade conduction across the aberrant pathway bypassing the AV node, producing a very rapid ventricular response after receiving ISOPTIN (or digitalis). Treatment is usually D.C.-cardioversion, which has been used safely and effectively after ISOPTIN. Because of verapamil's effect on AV conduction and the SA node, 1° AV block and transient bradycardia may occur. High grade block, however, has been infrequently observed. Marked 1° or progressive 2° or 3° AV block requires a dosage reduction or, rarely, discontinuation and institution of appropriate therapy depending upon the clinical situation. Patients with hypertrophic cardiomyopathy (IHSS) received verapamil in doses up to 720 mg/day. It must be appreciated that this group of patients had a serious disease with a high mortality rate and that most were refractory or intolerant to propranolol. A variety of serious adverse effects were seen in this group of patients including sinus bradycardia, 2° AV block, sinus arrest, pulmonary edema and/or severe hypotension. Most adverse effects responded well to dose reduction and only rarely was verapamil discontinued. **Precautions:** ISOPTIN should be given cautiously to patients with impaired hepatic function (in severe dysfunction use about 30% of the normal dose) or impaired renal function, and patients should be monitored for abnormal prolongation of the PR interval or other signs of excessive pharmacologic effects. Studies in a small number of patients suggest that concomitant use of ISOPTIN and beta blockers may be beneficial in patients with chronic stable angina. Combined therapy can also have adverse effects on cardiac function. Therefore, until further studies are completed, ISOPTIN should be used alone, if possible. If combined therapy is used, close surveillance of vital signs and clinical status should be carried out. Combined therapy with ISOPTIN and propranolol should usually be avoided in patients with AV conduction abnormalities and/or depressed left ventricular function. 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The following reactions, reported in less than 0.5%, occurred under circumstances where a causal relationship is not certain: ecchymosis, bruising, gynecomastia, psychotic symptoms, confusion, paresthesia, insomnia, somnolence, equilibrium disorder, blurred vision, syncope, muscle cramp, shakiness, claudication, hair loss, macules, spotty menstruation. **How Supplied:** ISOPTIN (verapamil HCl) is supplied in round, scored, film-coated tablets containing either 80 mg or 120 mg of verapamil hydrochloride and embossed with "ISOPTIN 80" or "ISOPTIN 120" on one side and with "KNOLL" on the reverse side. Revised August, 1984. 2385

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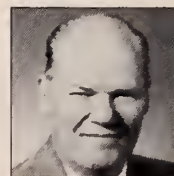
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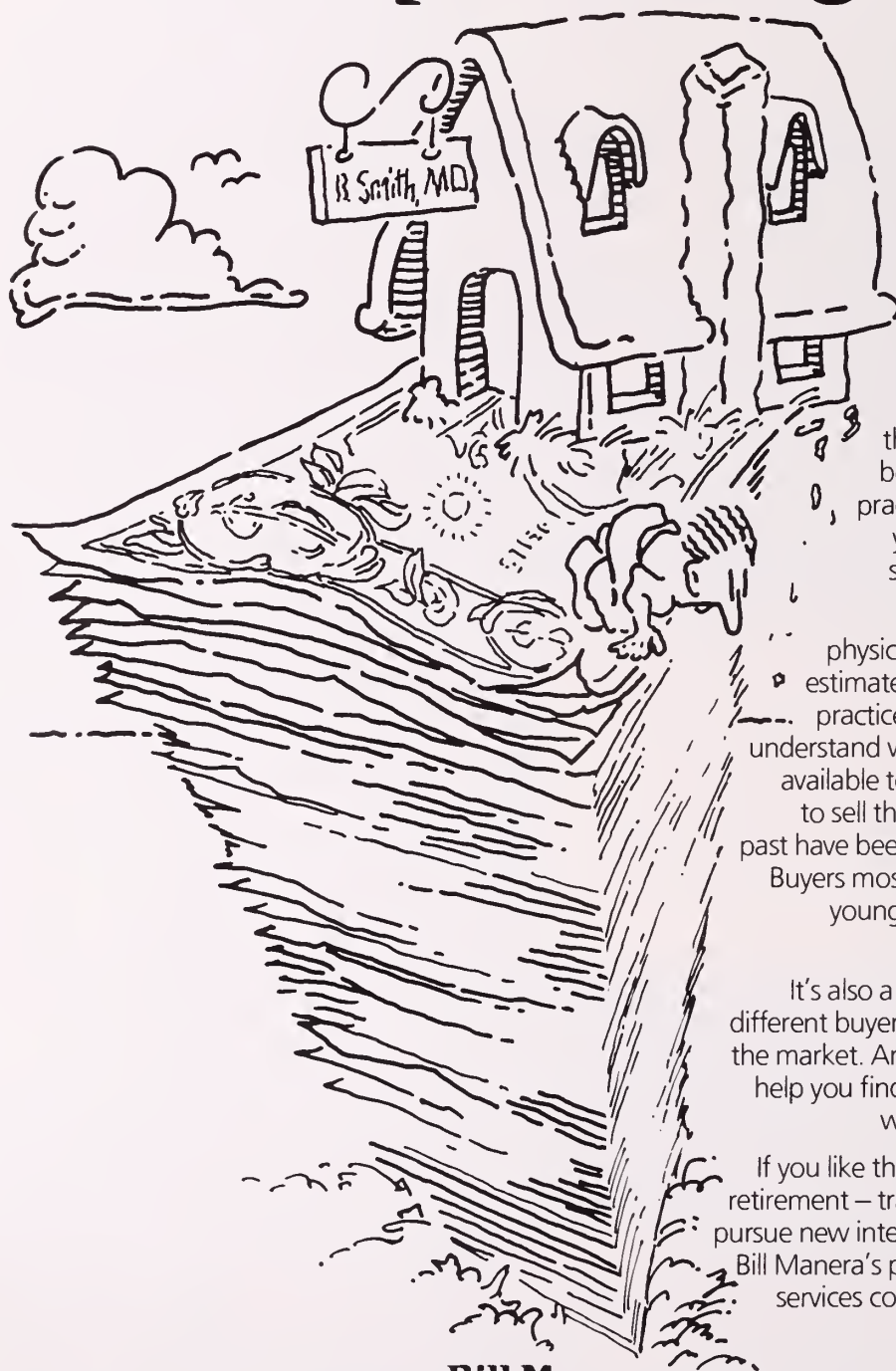
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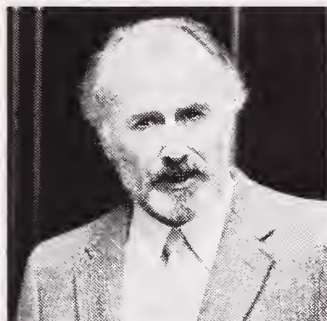
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<b>Sept. 10</b> , Wed., 6-9 p.m.	<b>Lawton</b> Holiday Inn, 3134 Cache Road
<b>Sept. 17</b> , Wed., 6-9 p.m.	<b>Muskogee</b> Holiday Inn, 800 South 32nd
<b>Sept. 24</b> , Wed., 6-9 p.m.	<b>McAlester</b> Holiday Inn, US Hwy 69 Byp South
<b>Oct. 8</b> , Wed., 6-9 p.m.	<b>Enid</b> Ramada Inn, 3005 W. Garriott Road
<b>Oct. 22</b> , Wed., 6-9 p.m.	<b>Oklahoma City</b> Conference Center, 5901 N. May (58th & May)
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I think a better name for Medicare, as it has turned out, would be "Fedicare," if anyone is serious about truth in labeling, that is.

In the beginning, I must believe, a few physicians who knew something about medical science, very little about human behavior, and nothing at all about the practice of medicine, huddled with some vote-seeking politicians and an assortment of power-hungry, empire-building bureaucrats and dreamed up a program which they called "Medicare." It was, they fantasized, an actuarially sound, broadly supported, physician-accepted plan which would make virtually free, comprehensive medical care available to our nation's older citizens.

A glorious bonanza for the Washington boondogglers, Medicare was launched as *the* panacea for the country's "nonsystem of health care," then being mismanaged by a "cottage industry." Taxpayers would love it because it looked like a free lunch. Physicians would love it because it guaranteed no invasion or modification of traditional patient-physician relationships. Employers and insurance companies and labor unions would love it because it removed the major financial liability from their pension and retirement funds. Hospitals and intermediary fiducial agents would love it because it looked like a breadwinner. The young and the old would love it because it relieved them of the actual and anticipated burden of paying health and hospital insurance premiums or costs. Everybody would love Medicare.

As with most fantasized love affairs, however, something's gone wrong. Medicare has become the taxpayers' most extravagant lunch. It has abrogated every aspect of the patient-physician relationship except the physician's liability. Young people are realiz-

ing that the taxes they must pay to support Medicare today make its anticipated benefits of tomorrow no bargain. Old people are becoming aware of the fact that Medicare is transferring responsibility for their medical care from their personal physicians to a burgeoning army of unqualified, financially and politically motivated bureaucrats. They have watched as their financial support of the program has steadily increased, and their benefits have steadily diminished.

Recently even hospitals and fiducial intermediaries, forced to loan money to Medicare in the form of deliberately delayed reimbursements, earned in good faith, are perceiving Medicare contracts as unilateral, non-negotiable paths to bankruptcy; certainly not breadwinners.

It is probable that the administrative costs of Medicare, the hidden, indirect costs as well as the more obvious direct costs of the program, long ago exceeded fifty percent of so-called premium income. A true level of seventy percent is not beyond reason. (Expecting that an honest determination of overhead costs will ever see the light of day is, however, quite beyond reason.)

Clearly, the provision of medical care has become a minor by-product of the socialistic fantasy called "Medicare." Its principal purpose appears to be its own preservation, the expansion of its own authority, and the absolute control of every hospital, every physician, and ultimately, every patient naive enough to consider himself or herself a "beneficiary" of Medicare.

Surely Fedicare would be a better title.

—MRJ

**D**ear Fellow Physician:

One of the many concerns facing us these days is the rather insidious problem of our inability to maintain control over the health and well-being of our patients, ie, the public.

We all need to unite in this one aspect. Our profession is that segment of society to which the responsibility for the health of the public is relegated. We, the physicians of America, are really the only group that has the expertise and the motivation to evaluate the health of the people and to determine what care is proper and necessary. However, more and more, third parties such as the government, insurance companies, and even hospital administrations, have begun to dictate what type of care we should give, how much care we should give, and in what fashion we should give this care. It is absurd to think that these groups, with very little knowledge and experience and usually with no deep concern other than cost, can really evaluate the quality and the sufficiency of medical treatment. These organizations bombard us with numbers of one type and another, attempting to prove one thing or the other. However, we all realize the relative inadequacy of statistics in evaluating the level of medical care and treatment. This is an intolerable situation and one that we as a profession cannot allow to continue and to grow. If we have any pride at all in our profession and feel any responsibility for the health and well-being of the public, this problem is basic and must be controlled.

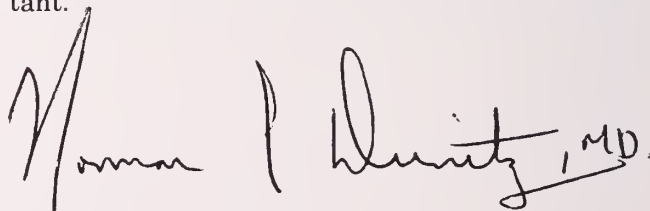


Unfortunately, I have seen and I am sure you have also, a rather slow erosion and acquiescence on the part of the physicians throughout the state of Oklahoma in allowing these third parties to dictate the progress and control of the delivery of medical care. There are many reasons why we are abdicating our position and responsibility, not the least of which is a fear of economic loss; but irregardless of the reasons we might have, this is one point upon which we must not give in.

It is obvious to many of us, particularly the older physicians, that giving in to these pressures at this point in time, including the economic arena, will prove to be beneficial only in the short term and that soon further limitations will be placed upon us. In the long run, our profession will suffer. The damage to our prestige in the community and our own sense of responsibility will suffer even more.

I realize it is easy to go along with the crowd and the sibyllic temptations of insurance companies, government agencies, hospital administrations, and other third parties, but I can assure you that once we have given up our own leadership in these fields, the medical profession will no longer be the same.

Fellow physicians — we need to be united in many ways; this problem is certainly one of the most important.



Norman L. Dunitz, MD

# Endoscopic Laser Therapy for Gastrointestinal Disorders

## Part III: Laser Therapy in Neoplastic Disease

(Third of four parts)

MARK H. MELLOW, MD

Perhaps the most exciting area of laser use in gastrointestinal disorders involves the treatment of gastrointestinal neoplasia. This article focuses on endoscopic laser use in the treatment of cancer of the esophagus and gastroesophageal junction.

Since, with the aid of flexible gastrointestinal endoscopes, laser fibers can be delivered directly to the site of intraluminal neoplasms, an opportunity exists for local antitumor therapy. Laser energy delivered at sufficient power will cause tumor tissue necrosis and destruction. Neoplasms of the esophagus, stomach, duodenum, ampulla, colon, and rectum have been treated with endoscopic laser therapy, the vast majority being esophageal and rectal. While treatment has been mainly palliative, curative treatment has been effective on occasion.

### Esophageal Cancer

Unfortunately, by time of diagnosis most patients with esophageal carcinoma are not treatable for cure. Radiation therapy is the most common primary treatment modality. In most instances beneficial effects are short-lived, with local tumor recurrence the rule. Local control remains the critical problem as luminal narrowing results in dysphagia, adds to the already poor nutritional status of the patient, and may be responsible for aspiration pneumonia. Until recently, current treatment modalities for palliation have in-

cluded chemotherapy, gastrostomy, esophageal dilatation, and prosthesis placement. Ideally, palliative treatment should have universal applicability, achieve its effect rapidly, have low morbidity, have long-lasting effect, and be usable for recurrence. It is clear that the above-named treatment modalities suffer from severe deficiencies when matched against this ideal palliative agent.

Endoscopic laser therapy for esophageal cancer has several appealing aspects: (1) Surgery and general anesthesia may be avoided. (2) Systemic side effects do not occur. (3) Treatment can be performed under direct vision. (4) Patients may be treated for recurrence, as no maximum dose of laser energy exists, as with radiotherapy. The important limitation lies in the fact that pathologic tissue outside of the esophageal lumen cannot be reached with the laser. Thus, if laser treatment is to be used as the sole treatment modality in a patient with esophageal cancer, it must be used with palliative intent.

However, a new concept has recently emerged; that is, employing the laser for its powerful local effect and combining it with other agents for more systemic effect. The Southwest Oncology Group (SWOG) has under consideration a multicenter study using multiple modalities on newly diagnosed patients with esophageal cancer, for curative intent. In this study, laser therapy will be used as the first treatment modality in the hope of improving nutritional status and performance status by rapidly establishing and maintaining luminal patency ("down-

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**Fig 1.** Laser fiber is passed out of tip of endoscope and is directed, at close proximity, to the tumor. Treatment is accomplished under direct endoscopic vision, and tissue injury can be confined to the target tissue.

staging" the primary lesion). Laser treatment is then followed by chemotherapy (5-FU and Cis-platinum) and radiation therapy. The combination of radiation therapy and chemotherapy has yielded some encouraging results thus far. In a recent SWOG study, 22% of 86 patients going to surgery after radiation and chemotherapy had no cancer detectable in the resected esophagus or celiac nodes. That study is still ongoing, and it is too early to know just how survival rates will be affected.

Adenocarcinoma of the distal esophagus and gastroesophageal junction has also been treated with laser therapy. Patients best suited for nonoperative therapy here would be those who could not be operated for curative intent (unfortunately, this is frequently the case). The use of lower thoracic and upper abdominal CAT scanning has been helpful in identifying extraesophageal disease. To date, there are no prospective randomized studies comparing standard surgical resection with laser treatment (alone or com-

bined with chemotherapy) in the palliative management of patients with gastroesophageal junction and distal esophageal adenocarcinoma. We have, however, had several patients survive more than one year after initial diagnosis of widespread distal esophageal cancer and nonoperative treatment.

The technique of laser treatment for esophageal and gastroesophageal junction cancer may be described as follows. As in gastrointestinal hemorrhage, the laser fiber, which is encased in a quartz waveguide, is passed through the biopsy channel of a standard endoscope. The beam is directed at the desired tissue site at a treatment distance of approximately half a centimeter. Treatment is directed at the most distally accessible portion of tumor, with treatment then progressing proximally in each session (Fig 1). Patients are premedicated as for a standard endoscopic procedure and treatment sessions are performed every other day and continued until easy passage of the endoscope beyond the prior obstruction is possible. Each treatment session takes no longer than 60 minutes. If the patient's clinical condition allows, treatments may be performed on an out-patient basis. Utilizing this technique, luminal patency has been achieved in a mean of three sessions (five days) (Fig 2).

Combining laser with the use of a newly developed tapered dilator (this allows initial widening of the lumen so that the laser can be passed to the bottom of the tumor) shortens the procedure even further. Some investigators have reported that treatment has been completed in one or two sessions. Laser therapy may be useful in esophageal cancer for purely palliative intent. In a recent study, we employed laser treatment as the sole treatment modality in patients who had recurrent disease after previous treatment (radiation therapy or surgery) or whose medical condition on presentation was felt to preclude surgery or full course radiotherapy. Of 30 patients, all except 3 had at least 90% luminal occlusion prior to treatment. Patients had a mean weight loss of 29 pounds and mean axial tumor length of 8 cm.

Utilizing the above described treatment protocol, esophageal luminal patency was achieved in 29 of the 30 patients in a mean of 3.3 sessions (seven days). Dysphagia improved in 25 patients and performance status improved in 18, presumably as a result of improved nutritional intake. In addition, survival in patients with squamous cell cancer, recurrent after initial radiation and then treated with laser, was significantly greater than in a similar group of pa-



**Fig 2a.** Pretreatment barium swallow showing complete esophageal obstruction in the mid-esophagus.



**Fig 2b.** Following three laser treatments, the obstruction has been relieved, and barium flows easily into the distal esophagus and stomach.

tients, matched for age, tumor length, and performance status, treated at our institution in the three years prior to laser availability (Fig 3).

### Complications

Perforation with tracheoesophageal fistula occurred in 2 of 30 patients during the course of treatment. In one, perforation resulted in massive aspiration pneumonia and death. In the other, an esophageal prosthesis was successfully placed and the perforation occluded. At the International Laser Symposium held in Washington, DC, (April 1985) complication rates for the participants' patients were compiled. Perforation occurred in approximately 7% of all treated patients. Induction of bleeding was quite rare, occurring in less than 1% of cases. Technical failure (the inability to achieve luminal patency) occurred in 8%.

As more experience with laser treatment for esophageal cancer is accumulating, several factors have been identified which appear to have a negative effect on the chances for short-term and long-term

success. Bad clinical prognostic signs include poor pretreatment performance status and severe pretreatment anorexia (as opposed to severe dysphagia, which can be favorably altered by treatment). Negative endoscopic prognostic factors include lesions near the cricopharyngeus, very long lesions that traverse the gastroesophageal junction, and lesions that are primarily infiltrative and not exophytic in nature. As treatment is expensive and resources are not widespread, it is important to identify these negative factors. It would do little good to establish luminal patency in a patient who is anorexic, bedridden, and riddled with painful metastases. On the other hand, patients who are weakened from their inability to swallow but who still maintain a desire to eat, can be greatly benefited by laser treatment.

### Summary

To summarize, endoscopic laser therapy for esophageal cancer is technically efficacious, is performed with routine endoscopic technique, and may be performed on an outpatient basis (the patient's

### Survival, from Recurrent Symptoms, in Esophageal Squamous CA<sup>a</sup>

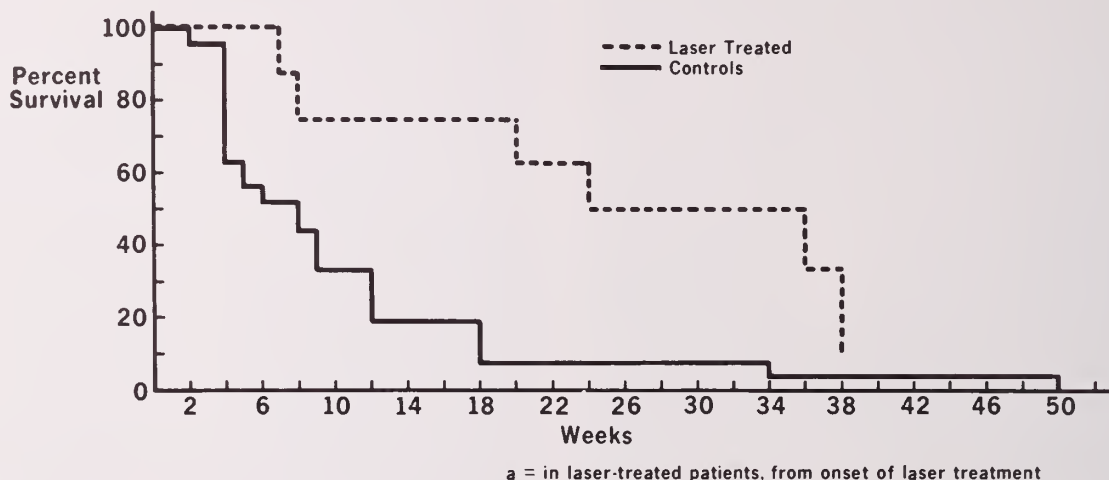


Fig 3. Survival in patients with squamous carcinoma of the esophagus, previously treated with radiation therapy, as measured from time of recurrent symptoms. Controls were treated in the standard fashion (ie, dilatation, gastrostomy, etc).

clinical condition permitting). Treatment is completed in approximately five days and can be repeated for recurrence. Treatment is usually palliative but is now being combined with additional modalities (radiation therapy, chemotherapy) for "curative" intent. Neither severity of pretreatment dysphagia, narrow luminal diameter, nor pretreatment weight loss are negative prognostic indicators, but patients with poor performance status and/or severe pretreatment anorexia tend to do poorly. Finally, early data suggest that palliative laser treatment may favorably affect survival.

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### Coming in August . . .

Papers being considered for publication in August include a case report of a screw worm larva in a human. Already scheduled is the final installment of the series "Endoscopic Laser Therapy for Gastrointestinal Disorders," a continuation of this month's discussion of laser therapy in neoplastic disease, and an article on prostaglandins and psychiatry.

# Spider Bites

ROBERT J. MORGAN, MD

**The diagnosis of spider bites is often speculative because few patients actually see the spider as it bites. Other insect bites, necrotizing vasculitis, and infections can produce skin and systemic findings that simulate those of spider bites. When the diagnosis of spider bite is unequivocal, the proper therapy is debatable. The following will explain why.**

Of the approximately 30,000 known species of spiders, about 50 may bite humans. Some bites cannot penetrate the epidermis and thus cause no symptoms. Some species' bites are painful just from the trauma and possibly from secondary infection, eg, the American tarantula (*Theraphosida* sp); some are painful, somewhat venomous, and can cause redness, swelling, itching, and even erosions, but are almost never lethal, eg, the wolf spider (*Lycosa* sp), the running spider (*Chiracanthium* sp), the jumping spider (*Phidippus* sp), and the garden spider (*Argiope* sp).

In other countries, venoms from some species have been so toxic that patients, usually children, have died within two hours after a bite, eg, the funnel-web spider of Australia (*Atrax* sp), and the wolf spider (*Lycosa* sp) of South America.

Bites from these spiders in the USA are variably painful but require only symptomatic therapy.

However, two species found commonly in the United States have venoms potentially dangerous enough to be disabling or fatal: (1) the black widow

or shoe-button spider and (2) the brown recluse or fiddleback spider.

**The black widow spider** (*Lactrodectus* sp) usually is shiny black, but may be reddish or brown in color, and has a spherical abdomen striped with an hourglass- or shoe-button-shaped patch that may be reddish, orange, pink, or even gray. It lives throughout the world, preferring to feed on flies, and is aggressive only when protecting its young.

In September, 1983, a black widow spider was taken to a school in Danburg, Tex. Subsequently, more than 400 baby spiders hatched, escaped through a wire mesh, and bit ten children. Newborn baby spiders can bite and can inject venoms, but ordinarily only the female's bite is capable of penetrating the skin of humans.

The female bite gives just a pinprick sensation, and often is inconsequential and unnoticed. Skin manifestations usually are so trivial that a dermatologist rarely would be consulted. However, patients have been seen with a boardlike abdomen, and punctate marks of a bite may be evident on the skin where pain is most severe.

Pain can become excruciating, developing within one-half to one hour and peaking in two to three hours after the bite occurs. Pains of appendicitis and coronary thrombosis may be simulated. Labored breathing, respiratory paralysis, headache, facial edema, salivation, systemic fever, chills, profuse local sweating, myalgia, anuria, priapism, painful feet, and symptoms of shock are the presenting symptoms.

Of the five or six components of the venom, the neurotoxin is the most dangerous. Small children may die, but the bite is seldom fatal for adults.<sup>1</sup>

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### Therapy for black widow bites:

1. Hot packs or ice packs should be tried for the local pain (usually neither heat nor cold will relieve the pain).
2. Inject site with xylocaine — may mix with corticosteroids since infection rarely is a complication.
3. Antivenin (Merck Sharp & Dohme) 2.5 ml administered intramuscularly in the anteriolateral thigh. This is hyperimmune horse serum, so *test for sensitivity* and be prepared for anaphylaxis. A second dose occasionally is necessary. It may be administered intravenously in saline 10-20 ml if the patient is in shock.
4. Analgesics may be needed. Some physicians feel that meperidine (Demerol) makes the pain worse, so other analgesics might be a better choice.
5. Calcium gluconate or calcium lactate 10 ml 10% administered slowly intravenously relieves the pain of muscle spasm, but relief is usually transient at best.
6. Other muscle relaxants, eg, Parafon Forte (McNeil) or Robaxinal (Robins) may be administered.
7. The pressure/immobilization method of first aid, so effective for snakebite, only potentiates the pain. The dangerous venom effects develop so slowly that this method of first aid, perfected by Pearn and Sutherland and the Commonwealth Serum Laboratories of Australia,<sup>2</sup> should *not* be used.

**The brown recluse or fiddleback spider** (*Loxosceles* sp), of which there are at least nineteen species, thirteen in the USA, usually is brownish but may be gray, black,<sup>3</sup> tan, or white. On the back of the cephalothorax is a marking shaped like a violin or fiddle. The name implies that they are shy, retiring, and nonaggressive, but if their habitat is disturbed both male and female will bite — with poisonous reactions. They live most abundantly across the southern United States, may be more prevalent in Latin America, and have been found in storage houses in Canada. They are nocturnal feeders, consuming insects, crumbs (don't eat in bed), and other spiders.

The fiddleback's bite can produce skin reactions that often require a physician's expertise. The bite reaction is variable, depending on unknown factors but also on such known factors as thickness of skin at the site, amount of venom injected, previous envenomations, and individual differences in victims.

The venom contains a calcium-dependent sphingomyelinase. Resulting pain also varies. If an appreciable amount of venom has been injected, an immediate sharp pain like a bee or wasp sting is felt. It usually is not severe and peaks in 2 to 18 hours after the bite.

The bite site may develop any of the following skin changes in the order mentioned, or may stop at any stage and never progress to the next: reddish, slightly tender papule, sometimes with two bright red puncta at sites of penetration of the chelicerae into the skin; surrounding erythema; wheal; local edema; blister; purpura; cyanosis; ischemia; infarction; necrosis with black eschar; and craterform ulceration up to six inches in diameter. Anesthesia may replace the painful early lesion. Final stages, even the ulceration, may be reached in from four days to two months. Calcium in tissues is needed for the toxin to cause necrosis. The ulcers may last months. Bite site lesions may develop, even to the stage of erosion, with little or no systemic reaction. Pyoderma and necrotizing vasculitis and infarction from emboli can simulate these bites.

Systemic reactions differ and can occur at any of the above stages, with the patient at times becoming frighteningly ill. Fever, chills, malaise, weakness, nausea, myalgias, disseminated morbilliform rashes, urticaria, petechiae, disseminated intravascular coagulation, jaundice, hemolysis, hemolytic anemia, thrombocytopenia, and renal failure have been reported.<sup>4-6</sup>

Management of patients with fiddleback spider bites is not as clear-cut as that with black widow bites. If the diagnosis is not decisive from the history and the clinical picture is not typical, a biopsy may be helpful. Tissue examination of early lesions will be nonspecific but may show endothelial damage and hemolysis as the venom attaches to erythrocyte cell membranes. Eosinophils usually are evident. If polymorphonuclear leukocytes are sparse or absent in lesions less than a week old, necrosis is not likely to occur. Harves and Millikan<sup>1</sup> have shown that complement as well as polymorphonuclear leukocytes are necessary to the development of severe necrosis. In lesions more than a week old, cytolysis of epidermal cells, liquefaction with polymorphonuclear leukocytes, lymphocytes, and histiocytes, often with bizarre nuclei, become progressively more prominent.

A retrospective diagnosis can be established with the lymphocyte transfer test, which turns positive four to six weeks after the patient is bitten.<sup>7</sup>

## Therapy for fiddleback bites:

If the diagnosis is decisive, a known fiddleback spider bite, the following options should be considered.

Early lesions (few hours old) without systemic symptoms:

1. Treat symptomatically, judiciously reassure, and observe daily for three or four days. Telephone contact for one week. Hemolysis and disseminated intravascular coagulation may not begin for three or four days after the bite.
2. Splint the bite site since venom spreads partly by motion.
3. If patient is seen within six hours after a bite by a large spider, excise a wedge around the site. Rees, Shack, Withers, et al,<sup>8</sup> injected various dilutions of venom into rabbits. Surgical excision at sites did not *always* prevent necrosis or wound dehiscence, but did so in 12 of 16 sites.
4. Inject intralesional triamcinalone with or without equal amount 1% procaine. Use procaine if the lesion is painful.
5. Give Dapsone 100 mg orally bid for 14 days. King and Rees<sup>9,10</sup> claim it "helps eliminate necrotic ulcers in guinea pigs and shows much promise in humans."
6. Administer analgesics as needed. Demerol may potentiate the pain, so use something else.

If necrotic ulcers develop, options are:

1. Clean with hydrogen peroxide, potassium permanganate, Betadine, or normal saline.
2. Debrisan to erosion after soaking.
3. Silvadene burn cream, triple dye, triple antibiotic, and Betadine solution have all been suggested for use after cleansing.
4. Excise ulcer and graft skin only after 6 to 8 weeks.
5. Let ulcer granulate in.

If systemic symptoms develop or widespread skin lesions occur:

1. Test urine for free hemoglobin or red blood cell fragments to determine hemolysis. Also check for thrombocytopenia, fibrinogenemia, and prolongation of clotting time.
2. If patient tests positive or is feverish, consider hospitalization.\*
3. Give prednisone, up to 100 mg in a single dose

bolus injection, or dexamethasone .1 mg/kg/day or 4 mg intramuscularly every six hours. This helps prevent and treat hemolysis but has no effect on necrosis.

4. Give heparin should intravascular clotting occur — it does not influence necrosis.
5. Packed red cells with SoluCortef are helpful if hemolysis seems severe.
6. Dialysis is used for evidence of renal failure.

What repellents and pesticides are effective?

It is recommended that whatever chemical is used, it will work best if sprayed directly on the spider.

- Diazinon (Spectracide and others), 4 ounces in 1½ gallons water
- Malathion, 6 ounces per gallon water
- Chlorphenothane spray
- Benzene hexachloride spray (Gammexane)
- DDVP (Vapona or Real Kill) fog or spray
- Lindane
- Trithion
- Pyrethrum



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\*A lawsuit in Texas (1985) was lost by physicians because a feverish patient was neither hospitalized nor given steroids systemically.



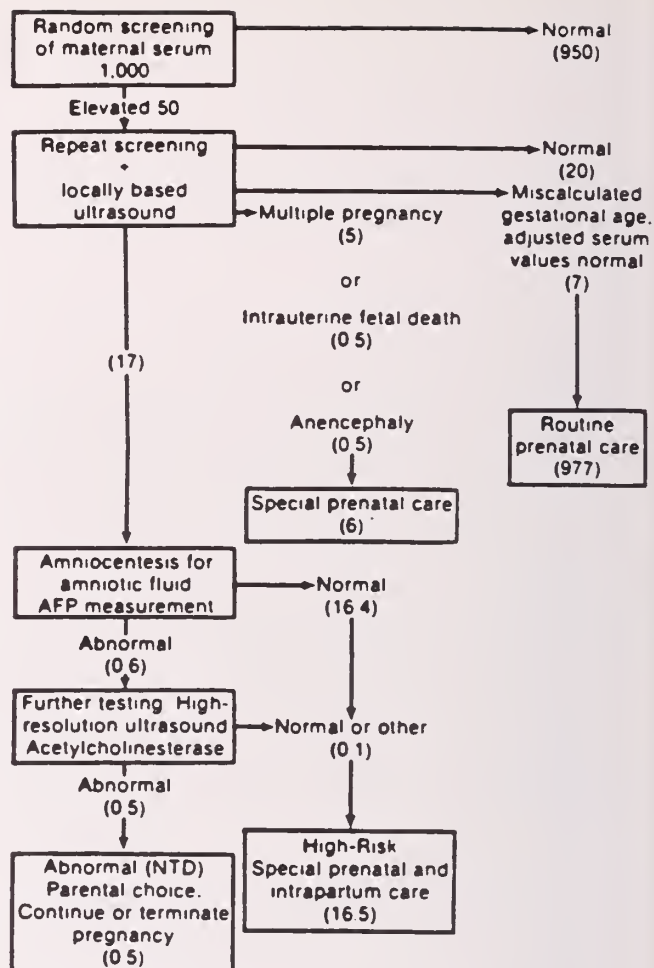
## News from the Oklahoma State Department of Health

### Maternal Serum Alpha-Fetoprotein Screening

Maternal serum alpha-fetoprotein (MSAFP) is the principal plasma protein of the fetus and normally is found in the amniotic fluid. There are increased concentrations of alpha-fetoprotein detected in the amniotic fluid when the fetus has a major skin defect through which there is exudation of fetal plasma. These include anecephaly, open spina bifida, and ventral wall defects (gastro-schisis and omphalocele).

Measuring the second trimester (15 to 20 weeks of gestation) maternal serum alpha-fetoprotein is a means of identifying pregnant women in the population (1 to 2 per 1,000) who are at high risk for having a child with one of the above defects. A number of other conditions, including some multiple anomaly cases, cystic hygromas, and some renal anomalies produce inconstant, but higher-than-expected MSAFP levels. There is also a rough correlation between increasing levels of MSAFP and the risk for an intrauterine demise, a growth-retarded fetus/neonate, premature labor, and intrapartum or neonatal death. A fetus "in trouble" but without a structural defect tends to release more AFP into maternal serum, though the mechanism is unclear. Overall, there is a five-to-sixfold elevated risk for one of these complications with unexplained elevations in MSAFP.

It is important to remember that MSAFP is not a diagnostic test and that such factors as mistaken gestational age and twins can also cause elevated MSAFP levels. The screening/diagnostic process is summarized in the accompanying chart. Further information regarding the use of MSAFP in identification of the high risk pregnancy may be directed to Vicki Stumbaugh, PhD, Genetics Counseling Network, Oklahoma State Department of Health, phone 405/271-4476.



Modified from ACOG Technical Bulletin, no 67, October 1982

DISEASE	April 1986	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	3	4	5	5
CAMPYLOBACTER INFECTIONS	13	52	63	—
ENCEPHALITIS, INFECTIOUS	1	5	11	10
GIARDIA INFECTIONS	11	53	65	—
GONORRHEA (Use ODH Form 228)	1122	4152	3866	4919
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	22	81	79	—
HEPATITIS A	31	109	172	174
HEPATITIS B	21	55	61	78
HEPATITIS, NON-A-NON-B	5	17	23	—
HEPATITIS UNSPECIFIED	6	20	29	61
MEASLES (RUBEOLA)	2	4	0	2
MENINGITIS, ASEPTIC	3	14	10	19
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	6	25	27	26
MENINGOCOCCAL INFECTIONS	2	11	14	16
PERTUSSIS	1	21	51	42
RABIES (Animal)	7	20	38	62
ROCKY MOUNTAIN SPOTTED FEVER	5	6	13	14
RUBELLA	0	0	0	0
SALMONELLA INFECTIONS	66	117	87	98
SHIGELLA INFECTIONS	20	50	50	81
SYPHILIS (Use ODH Form 228)	17	62	67	75
TETANUS	0	0	0	0
TUBERCULOSIS	19	67	75	99
TULAREMIA	1	2	1	3
TYPHOID FEVER	0	1	0	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	10
BRUCELLOSIS	0
LEGIONNAIRES DISEASE	5
MALARIA	2
REYE SYNDROME	3
TOXIC SHOCK SYNDROME	12
RABIES	
MAYES	Skunk 1
LINCOLN	Skunk 1
WASHITA	Skunk 1

# Election Year 1986

ROBERT W. BAKER III  
OSMA Associate Director

"Public confidence in the elective process  
is the foundation of public confidence in government."

—President Lyndon B. Johnson  
Letter to Congressional leaders  
May 26, 1966

**T**he two most important facts about elections are that they are losing popularity and that they are more important than ever. If these facts seem to be mutually contradictory, that is part of the problem of the elections. Free elections are held in fewer countries than they used to be. In this country, a smaller proportion of the public is voting. In 1960, for example, well over 60% of the eligible voters cast their ballots in the Presidential election. In 1976, about 55% voted. With embarrassing regularity, the percentage of eligible voters who actually go to the polls in the US falls far short of the percentages in the democracies of Western Europe. This has happened even though the American electorate is now called upon to vote on more issues than ever before, including the selection of government officials.

**YOUR INVOLVEMENT IS CRUCIAL.** For organized medicine to prosper in the legislature and in congress, we must first prosper at the polls.

## Upcoming 1986 Congressional Elections

As politicians, political scientists, party analysts, Washington pundits, and just plain folks ready themselves for the upcoming election campaigns this fall, one must take a look at the overall political scene before hazarding any opinions or guesses as to what

November 4, 1986, might bring. Most insiders have been keeping the closest watch on the political positioning associated with the United States Senate, primarily due to the more volatile and high profile nature of senate races and the fact that Democrats believe 1986 is their last good shot at wresting control away from the Republican majority until well into the 1990s.

A total of 34 senate seats are up for grabs; in an unusually top-heavy year for one political party, the Republicans will have to defend 22 of these seats. Thought to be particularly vulnerable is the freshman class of GOP senators who were swept into office in 1980 by the first Reagan landslide. Those senators are: Paula Hawkins (Florida), James Abnор (South Dakota), Robert Kasten (Wisconsin), Steve Symms (Idaho), Jeremiah Denton (Alabama), Mac Mattingly (Georgia), DON NICKLES (Oklahoma), Mark Andrews (North Dakota), Slade Gorton (Washington), and Arlen Specter (Pennsylvania). First termers Al D'Amato (New York), Charles Grassley (Iowa), Dan Quayle (Indiana), and Warren Rudman (New Hampshire) appear safe for the time being.

In addition, the GOP is left to defend the seats of four retiring incumbents. They are Charles

---

Mathias (Maryland), Paul Laxalt (Nevada), Barry Goldwater (Arizona), and John East (North Carolina).

This does not mean the Democrats are without worry. They, too, have to defend senate seats which merit political concern. Louisiana, Colorado, and Missouri all have "open" seats as the result of retiring Democratic senators (Russell Long, Gary Hart, and Thomas Eagleton, respectively), while Alan Cranston of California and Patrick Leahy of Vermont are widely viewed as vulnerable targets.

Most of the challengers and candidates have already announced their intentions, so the nature of these senate races has begun taking shape. Several incumbents find themselves facing tough, well-funded and well-known opponents, as in the case of Florida's Paula Hawkins, Idaho's Steve Symms, South Dakota's Jim Abner, and Oklahoma's Don Nickles, who is challenged by Congressman James R. Jones of Tulsa.

The outcome on the other side of Capitol Hill is far less in doubt, although Oklahoma's first congressional seat, being vacated by Congressman Jones, will undoubtedly provide Tulsans with a hotly contested race. While many political historians like to cite the "six-year itch" (a twentieth century American phenomenon whereby voters toss members of a second-term President's party out of office), it remains to be seen whether Ronald Reagan's current popularity can prevent and Democrats can create just such a situation.

### Upcoming 1986 State Elections

Oklahoma's entire State House of Representatives, 101 members, will all be up for election in 1986. The Oklahoma State Senate, which consists of 48 members, will have 24 members up for election this fall. Those senators up for reelection are:

Stratton Taylor, Claremore  
Joe Johnson, Heavener  
Roy Boatner, Calera  
Robert Miller, Beggs  
John Dahl, Barnsdall  
John Young, Sapulpa  
Darryl Roberts, Ardmore  
Lee Cate, Norman  
Ralph Chaote, Hennessey  
Kenneth Landis, Duncan  
Gilmer Capps, Snyder  
William O'Connor, Ponca City  
(presently not running for reelection)

Al Terrill, Lawton  
Robert Cullison, Skiatook  
Frank Rhodes, Catoosa  
Wayne Winn, Weatherford  
Mike Combs, Bethany  
James Howell, Midwest City  
Marvin York, Oklahoma City  
Bernest Cain, Oklahoma City  
E. Melvin Porter, Oklahoma City  
E. W. Keller, Bethany  
Gerald Wright, Tulsa  
Bill Dawson, Seminole  
(presently not running for reelection)


You will also have the opportunity to elect a new Governor, Lieutenant Governor, Attorney General, and Auditor and Inspector.

Overall, with the inclusion of the six congressional seats up for grabs and the one senate seat, Oklahomans will have the opportunity to vote on 136 candidates for office.

It is crucial that you become involved if we are to have success in the Oklahoma State Legislature and the United States Congress. The key points of involvement are:

1. If you are not registered to vote, register to vote immediately! Contact your county election board for directions to the nearest voter registrar in your area.
2. Increase your political awareness and influence by contributing your time and/or money to your favorite candidate's election campaign.
3. Consider joining your colleagues, over 1,200 of them, in contributing to OMPAC.
4. Be prepared to vote. Know your state senator, your state representative, and your US Congressman. If you do not know who your representative is, you may either contact your local county election board or contact the OSMA office at 843-9571 and request our assistance. We will be happy to help.

Key election dates to remember are:  
Tuesday, August 26, 1986 — Primary Election  
Tuesday, September 16, 1986 — Run-off Primary  
Tuesday, November 4, 1986 — General Election

The candidacy filing period closes on Wednesday, July 9, 1986, at 5:00 PM. 

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G. Rainey Williams, MD, honored

## Oklahoma physician to become Hall of Fame member this fall

The Oklahoma Heritage Association has announced that Oklahoma City physician G. Rainey Williams, MD, is one of eight outstanding Oklahomans to be inducted into the Oklahoma Hall of Fame on Statehood Day, November 15, 1986.

Dr Williams is chairman of the Department of Surgery at the University of Oklahoma College of Medicine. In 1964 he performed the pioneering surgery to re-attach the severed arm of an Oklahoma State University basketball player, for which he received the prestigious Shipley Award from the South-

ern Surgical Association. Dr Williams has held numerous leadership positions in professional organizations, including service as chairman of the American Surgical Association, president of the Southern Surgical Association, and member of the Board of Governors of the American College of Surgeons.

He is active on behalf of the University of Oklahoma and numerous organizations of a civic and cultural nature and recently received the prestigious Dean's Award for medical and community service in recognition of his service in both the medical and civic fields.

The other honorees for 1986 are Lyle H. Boren, Major General Charles P. Brown, Nancy Frantz Davies, James Garner, Julian J. Rothbaum, James E. Stewart, and Henry Zarrow. □

## Trustees approve nineteen new OSMA Life Memberships in May

At their May 7 meeting, the Oklahoma State Medical Association Board of Trustees approved nineteen new Life Members.

Oklahoma City physicians awarded Life Memberships are James C. Amspacher, MD; Marvin K. Margo, MD; John C. Pickard, MD; John W. Records, MD; and L. D. Threlkeld, MD.

New Life Members from Bartlesville are Virginia Shipman Allen, MD; Ralph C. Emmott, MD; Forrest C. Lawrence, MD; and Herbert L. Owen, MD.

Robert L. Anderson, MD, and Edward M. Thorp, MD, from Cushing were named, as were Patrick Shanks, MD, and John W. Williams, MD, of Enid.

Also receiving Life Memberships were Frank L. Bradley, MD, Talihina; Paul D. Macrory, MD, Bethany; Carl C. Morgan, MD, Tulsa; Vester M. Rutherford, MD, Midwest City; Haskell Smith, MD, Stillwater; and Jack T. Terry, MD, Ponca City.

To be eligible for a Life Membership, an OSMA member must meet one or more of the following requirements: (1) Be retired from the active practice of medicine due to ill health or age; (2) Be engaged in the active practice of medicine for fifty years or more; (3) Be seventy years of age or older. □



**John A. McIntyre, MD**, (right) of Enid receives this year's A. H. Robins Award for community service. Presented by Michael Haugh, MD, at the OSMA Annual Meeting in May, the Robins award is given annually to the physician who best exemplifies dedication to both his profession and his community. Dr McIntyre is a past president of the OSMA.

Over 60 participants this year

## Thank you, exhibitors, for making Tulsa meeting a success

Some sixty exhibitors and contributors played a major role in the success of this year's OSMA Annual Meeting in Tulsa, May 8-10. Filling the Exhibit Hall at the Tulsa Convention Center, their booths and displays presented information on a variety of goods and services and provided a colorful gathering place for delegates and guests on the go.

The OSMA extends its thanks once again to the supporters of this year's Annual Meeting:

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**Don P. Wilson, MD, Tulsa (left),** receives the 1985 Charlotte S. Leebron Memorial Trust Award from JOURNAL Editor-in-Chief Mark R. Johnson, MD. Dr Wilson and his coauthors, Nancy J. Carpenter, PhD, Tulsa, and John H. Holcombe, MD, Oklahoma City, were selected by the JOURNAL's Editorial Board for having written the most worthy scientific paper published in 1985, "Turner Syndrome: Clinical Investigations and Review."

*New facility opened in March*

## **Latest detection methods used at OKC's Breast Care Center**

Early detection of breast cancer almost always has a happy ending; in nearly 90% of the cases, "early detection leads to a cure," according to Larry K. Kilbrew, MD, physician administrator at the Oklahoma Breast Care Center, which opened in Oklahoma City this spring.

Founded by a group of 30 Oklahoma City physicians, the center emphasizes early detection. The latest in detection technology is being used, along with programs including breast self-examination, breast imaging, and counseling. Educational services including lectures and classes are also available.

Breast cancer is a frightening subject for many women, so special attention has been given to making the Breast Care Center a "non-hospital" setting. Offices have been decorated with antiques and other living room items in an effort to create a nonthreatening environment that will help put anxious patients at ease.

The methods used to detect breast cancer include mammography, which detects some tumors before

they can be felt, and breast ultrasound and lite scanning, new methods which use no radiation. The process of lite scanning will be helpful for women with dense breasts, implants, and fibrocystic changes.

According to the director of the center, "A typical exam takes less than an hour. A report can be delivered to the patient's physician in less than 24 hours. If a patient does not have a personal physician, the patient may choose from a list provided by the center."

Oklahoma City physicians who are limited partners in the Oklahoma Breast Care Center include William Bernhardt, Walter Bowlan, Douglas Brant, Dudley Powers, Dean Brown, James Gilbert, Jerald Gilbert, Leon Gilbert, John Bumpus, Ken Whittington, Will Wyatt, R. Chanes, Gregory Cox, Royce Everett, James Funnell, Gary Strebel, David Kallenburger, Irwin McLendon, Dennis Mask, B. J. Matter, John Pittman, Tony Puckett, Karen Reisig, Billy Sipes, Cullen Thomas, and James Totoro. □

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Heimlich maneuver also discussed

## CPR methods updated and simplified for lay persons

Revised standards and guidelines for cardiopulmonary resuscitation (CPR) and emergency cardiac care (ECC), incorporating new scientific information and simplified instructions, appear in a recent *Journal of the American Medical Association*.

Since its introduction 25 years ago, CPR has been responsible for the saving of thousands of lives. Survival rates are 25% with early bystander intervention, backed up by efficient emergency medical services, compared with survival rates of only 5% without bystander intervention and adequate backup services. Survival in numbers approaches 250 lives each day.

Prominent among the revised guidelines is a new instruction that resolves the back blow-Heimlich maneuver controversy: "The Heimlich maneuver is designated as the preferred method to dislodge foreign matter from the airway: that is, back blows have been virtually eliminated," observes Carlotta M. Rinke, MD, editor of the special CPR issue.

"Reservations are expressed, however, about the use of the Heimlich maneuver in infants less than one year old, and with a dearth of scientific data, only back blows and chest thrusts are recommended for infants."

Additional new information concerns the potential for disease transmission from CPR training manikins, with a recommendation that persons known to have hepatitis B antigen or acquired immunodeficiency syndrome (AIDS) not participate in the hands-on manikin training.

Also new is a major rethinking of the physiology and application of mouth-to-mouth ventilation to a respiratory arrest victim. Instead of the previously taught four quick, full breaths, rescuers now will be taught to administer two initial ventilations of about 1.5 seconds each. The recommended number of chest compressions per minute, formerly 60 to 80, has been increased to 80 to 100.

New guidelines for emergency medical technicians include a recommendation that they be trained to recognize ventricular fibrillation and learn the skills of defibrillation. "It is now an incontrovertible fact that early defibrillation of cardiac arrest victims is associated with survival," says Rinke. "This recommendation is couched in the context of strict medical control," she adds. "Specifically, in the treatment of out-of-hospital ventricular fibrillation, three immediate and consecutive energy discharges should

be administered as soon as the equipment is available in contrast to the 1980 Standards, which recommend two consecutive defibrillation attempts."

To simplify teaching, lay persons will be taught only one-rescuer CPR, while medical professionals will continue to be trained in the two-rescuer sequence. In addition, in the interests of safety, efficacy, and ease in learning and performing, lay persons will be taught only the head tilt/chin lift method of opening the airway.

The revised guidelines were developed at a national conference last year sponsored by the American Heart Association, American Red Cross, American College of Cardiology, and National Heart, Lung, and Blood Institute and attended by representatives from all United States agencies involved in CPR training as well as representatives from 22 foreign countries, 30 medical schools, and various other agencies. □

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## Drug use information subject of newly released USP book

A new edition of the consumer drug-use information paperback book, *About Your Medicines*, has been published by the United States Pharmacopeial Convention, Inc (USP). *About Your Medicines* makes available to consumers a lay-language version of the drug-use information base that USP provides to health professionals in *USP DI*. The new 1986 edition of *About Your Medicines* updates the information on many of the drugs covered in the previous edition and adds information about newly approved and other widely used nonprescription and new prescription drugs.

The book includes monographs for over 400 drugs or combinations, representing over 2000 brand name and generic prescription and nonprescription drug products. Each monograph offers information on the drug's proper use, side effects, precautions, interactions, and storage, and notes information that should be considered before the medication is taken. Special precautions for persons who are pregnant, breast-feeding, diabetic, geriatric, pediatric, or have high blood-pressure, are provided where considered relevant. Bold type identifies especially critical information. Drugs are listed by their generic names, but brand names are cross-referenced in the index.

*About Your Medicines* offers answers to many common consumer questions, explaining what to do if a dose is missed, whether foods, alcohol, aspirin, or other drugs can be used with the medicine, and how the medicine should be stored.

This lay-language guide to the most frequently used prescription and nonprescription medicines is product of the USP Committee of Revision and its extensive network of advisory panels. *About Your Medicines* is an abridged version of Volume II of *USP DI, Advice for the Patient*.

For more information about the book, *About Your Medicines*, or the USP and its programs, contact the Department of Public and Professional Affairs at USP headquarters, 12601 Twinbrook Parkway, Rockville, Maryland 20852, (301) 881-0666. □

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**Oklahoma Congressman David McCurdy, (left)** Norman, visits with OSMA Executive Director David Bickham and Secretary-Treasurer Raymond L. Cornelison, Jr., MD, after conducting a session on foreign policy at OSMA headquarters. The special meeting this spring was for the OSMA Student Section.

## College of Radiology states Chernobyl no danger to USA

Concluding that no health risks for the American people will be demonstrated, the American College of Radiology commented recently on the probable effects of the Chernobyl reactor accident in the Soviet Union.

The statement, prepared by members of the College's Committee on Radiologic Units, Standards and Protection, notes that for distances greater than 100 miles beyond the reactor site, instruments will detect increased radiation, but there will likely be no observable biological effects within the first five years, depending on weather and topographic conditions.

In its statement, the College said:

\*In the United States, pregnant women and their fetuses face no increased danger.

\*There will be no detectable increase of cancer in the US because of this event.

\*Nursing mothers should have no concern about the safety of their milk.

\*People living in the US can expect no genetic damage from the accident.

\*No special precautions need be taken concerning food.

\*Patients need have no fears concerning diagnostic x-ray examinations.

\*There should be no need for concern in traveling to Europe, provided one goes no closer than 100 miles from the accident site. □

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## IN MEMORIAM

### 1985

<i>E.C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>Forest R. Brown, MD</i>	<i>March 19</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hanna B. Karam, MD</i>	<i>March 28</i>
<i>John R. Cotteral, MD</i>	<i>April 30</i>
<i>Ernest S. Kerekes, MD</i>	<i>June 8</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin Jesse Nelson, MD</i>	<i>June 13</i>
<i>Robert L. Kendall, MD</i>	<i>June 21</i>
<i>Marion K. Ledbetter, MD</i>	<i>July 3</i>
<i>James Floyd Moorman, MD</i>	<i>August 8</i>
<i>Oscar R. White, MD</i>	<i>August 14</i>
<i>Maurice P. Capehart, MD</i>	<i>August 29</i>
<i>Meredith M. Appleton, MD</i>	<i>September 7</i>

<i>Robert A. Northrup, MD</i>	<i>September 8</i>
<i>Carl H. Bailey, MD</i>	<i>September 9</i>
<i>Hugh B. Spencer, MD</i>	<i>September 13</i>
<i>Bernice E. McCain, MD</i>	<i>September 14</i>
<i>Minard F. Jacobs, MD</i>	<i>September 30</i>
<i>Robert Ray Rupp, MD</i>	<i>October 2</i>
<i>William C. Moore, MD</i>	<i>October 24</i>
<i>Michael Wayne Durbin, MD</i>	<i>November 13</i>
<i>Alan Luis Gorena, Jr., MD</i>	<i>November 19</i>
<i>William Hampton Garnier, MD</i>	<i>November 20</i>
<i>Jesse Ray Waltrip, MD</i>	<i>November 30</i>
<i>Charles F. Obermann, MD</i>	<i>December 30</i>

### 1986

<i>Alexander Poston, MD</i>	<i>January 3</i>
<i>Francis M. Duffy, MD</i>	<i>February 5</i>
<i>Edward L. Leonard, MD</i>	<i>February 14</i>
<i>Fred D. Switzer, MD</i>	<i>May 10</i>
<i>Phillip Wade Jones, MD</i>	<i>May 18</i>

## DEATHS

### Phillip Wade Jones, MD 1952 - 1986

Tulsa physician Phillip W. Jones, MD, died May 18 after an extended illness. A native of Enid, Dr Jones earned his medical degree at the University of Oklahoma College of Medicine in 1978 and completed a residency in radiation oncology. He was an assistant professor and director of radiation oncology at the City of Faith Medical and Research Center.

### Fred D. Switzer, MD 1908 - 1986

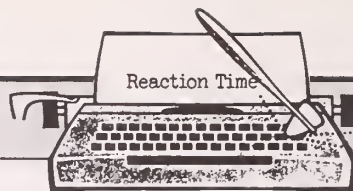
Life Member Fred D. Switzer, MD, an ophthalmologist in McAlester since 1953, died in that city on May 10, 1986. Born in Fort Towson, Dr Switzer was graduated from the University of Oklahoma School of Medicine in 1936. He entered the Army Medical Corp in 1940 and was assigned to Kelly Air Force Base in San Antonio. Thirteen years later he moved to McAlester to become a member of the McAlester Clinic. When he reached retirement age, Dr Switzer left the clinic and opened his own office in McAlester.

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## Nowata MD asks colleagues to move against Medicare mess

*To all Oklahoma physicians:* I recently scheduled a meeting with a Congressional liaison on the subject of Medicare. Many topics were discussed. I think we both learned a great deal. The most disturbing thing I heard was that the Congressmen had not heard anything from us about DRGs, PROs, etc, in quite a while and were assuming that we were accepting the changes.

I realize that tort reform is a top priority, but these very important people are getting some real misconceptions. If you have read your mail, you will notice that the PRO plans to review Part B Medicare on January 1st — Happy New Year!! They also plan to prepare a list of doctors to use for second opinions. They also will now deny payment based on “poor quality of care” based on their own (to be determined) criteria.

My main concern for all these changes is that it continues to distract us from patient care. It costs us

all to review, copy, phone, and explain all these regulations to patients. There will be no one else to do it. You will also notice that the fee freeze continues.

We need desperately to cooperate with the powerful senior citizens' lobbies to halt this mountain of paperwork. Traditionally we have been the best of friends, allied for quality health care. We need to convert these individual doctor-patient relationships into a reform movement to bring quality of care back as a top priority (and topple cost-cutting).

The legislation is now law, but laws can be changed and even replaced. Work with your local senior citizen groups. They are your friends, your patients, and your route out of the current Medicare rut.

*Robert C. Bowman, MD  
Nowata*



**Kirk Johnson, AMA legal counsel, addresses the OSMA Leadership Conference held in April at the Oklahoma City Marriott.**

### MISCELLANEOUS ADVERTISEMENTS

Miscellaneous advertising is available at the rate of \$10 per month per vertical inch or any portion thereof (ie, 1-7 lines is \$10, 8-14 lines is \$20, etc). Rates are *not* prorated for fractions of an inch. One inch of space contains 7 lines of copy averaging 55 characters each. The first line of the ad will automatically be set in all capital letters and averages only 38 characters. Count every letter, space, and punctuation mark as a character.

Box numbers will be assigned upon request at no additional charge. When requesting a box number, the last line of the ad must read: Reply JOURNAL BOX 00, c/o OSMA. This will add 32 characters and must be included.

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Typewritten copy is preferred. Otherwise, print very legibly in ink. Ads will not be accepted on the telephone. Be sure to indicate how many times the ad is to run, and for the JOURNAL's records, please include a name, address, and telephone number where you can be reached if necessary. Ads must be received by the first of the month preceding the month of publication.

In writing your ad, remember that it will be read statewide; include complete address and/or telephone information. If discussing employment, be sure to specify whether you are seeking a position or trying to fill one.

Enclose payment with your ad and mail to: OSMA JOURNAL, 601 Northwest Expressway, Oklahoma City, OK 73118. OSMA members and state agencies will be invoiced upon request.

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**“We must  
all hang together,  
or assuredly we shall all  
hang separately.”**

*Benjamin Franklin, July 4, 1776*

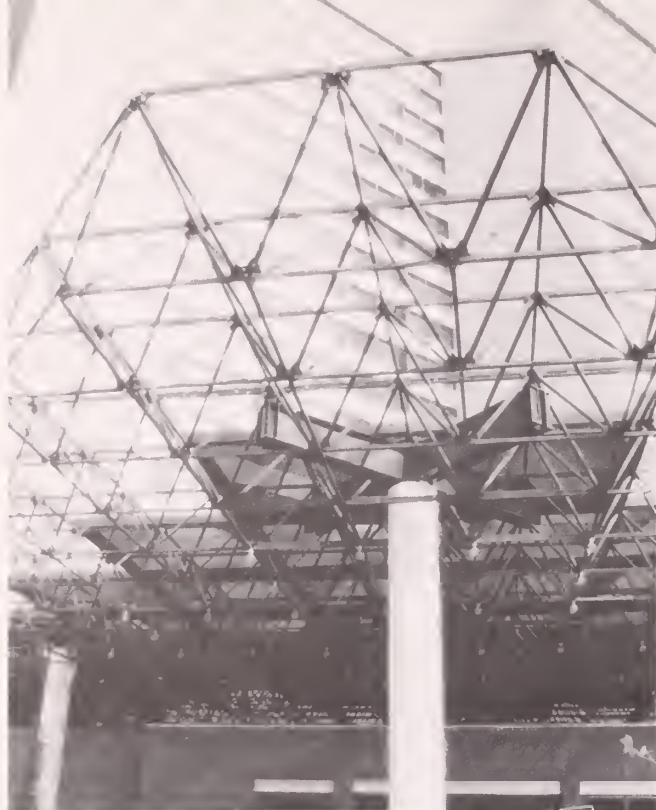
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**OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE**

contact  
Larry L. Long, MD, Chairman  
or  
Robert W. Baker, Director  
at  
1-800-522-9452

Tulsa, May 8-10

# '86 ANNUAL MEETING





Geometric steel soars above the entrance of Tulsa's Excelsior Hotel, "home" for most of this year's Annual Meeting participants.

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# OSMA House of Delegates

## REPORT OF THE PRESIDENT

Mr Speaker, members of the House of Delegates, and guests:

It has truly been an honor for me to be your President. The confidence you have placed in me has enriched my life both personally and professionally, Lucile and I wish to take this opportunity to thank each of you for allowing me the privilege to serve you in this capacity.

As I stressed in my report as President-Elect, the need to "Get Involved — Participate," I believe was achieved at all levels of association activity. To my colleagues who gave of their time to travel to the Capitol, to the OSMA staff that was always available to me and to the undying devotion of our council members and officers of this association, I thank you.

The challenge and activities involving your association made my term as president very busy and challenging. In the early part of my tenure, we traveled to Washington, DC, for the American Medical Political Action Committee annual meeting. This meeting gave the OSMA participants the opportunity to meet with our Congressional Delegation and discuss the problems plaguing our profession. On the congressional level we fought the continuation of the physician fee freeze and urged Congress to provide Oklahoma with an equitable one-zone reimbursement level for Medicare. Through our federal relations program, we were granted a meeting with high-level HCFA officials to discuss the single-zone project. Although the deficit budget situation blocked our opportunity to be given a demonstration project grant, our efforts have not gone unnoticed and we intend to continue our pursuit of one zone in Oklahoma.

Another opportunity to visit Washington, DC, was afforded the OSMA when we attended the Interim Meeting of the AMA House of Delegates in December. We were extremely pleased with the performance of your AMA Delegates and Alternate Delegates as they, once again, were leaders on numerous resolutions and floor actions. Our Delegation has done a tremendous job and I congratulate each of them on a job well done. In addition, Dr Perry Lambird was successful in his campaign to be elected to the Council on Medical Service and Dr Joe Crosthwait was appointed to a special committee on public relations.

Closer to home, the OSMA joined forces with over 60 other business and trade associations in a quest for meaningful tort reform. The Oklahomans Against Lawsuit Abuse, backed strongly by this association, has taken a major step towards realizing tort reform. Our association's strength at the State Capitol was very apparent and I urge your continued involvement to attain our tort reform goals. The legislators were impressed by doctors' participation in the Capitol rallies! We must realize that a project of this nature will take some time. However, in a legislature controlled by trial attorneys we have made great strides. We must not quit now. Your support of OMPAC and your individual work at the county level is very instrumen-



**ELVIN M. AMEN, MD**  
**OSMA PRESIDENT 1985-86**

tal to the future success or failure of our legislative goals. OMPAC membership and funds are at an all-time high thanks to Robert, Otie Ann, and Larry Long.

During a special called meeting of our House of Delegates you voted unanimously for an assessment for both PLICO and our portion of the Return to Reason Coalition. The assessment for PLICO will provide the necessary additional surplus that premium increases necessitate. I congratulate this House on its decision to keep the PLICO ratios satisfactory both to the regulatory bodies in Oklahoma and to reinsurers everywhere.

The Coalition portion of the assessment will enable the OSMA to continue to be a leader in the Coalition and keep our influence at a visible level.

1986 brought a change in the number of classes in PLICO. The newly implemented 9-class rating system was incorporated so all Oklahoma doctors could realize the benefit of our better loss experience and lower costs. This new 9-class system was also necessary to keep PLICO's participation, throughout the market, on a similar competitive rating system . . . I congratulate the PLICO Board and this body on keeping our rates some of the lowest in the country. We also still have occurrence-type coverage.

Finally, as you know, the OSMA-PLICO Loss Prevention Seminars are now mandatory. Your attendance at these seminars, once every three years, will give you additional insight into your company and keep you abreast of the numerous changes in the area of loss prevention.

In mid-April the first OSMA Leadership Conference was held in Oklahoma City. This conference was highly successful with attendance exceptionally good. It was an excellent opportunity for all conferees to learn guidelines for leaders, parliamentary procedure, legislative pointers, and to be brought up to

date on activity at the national AMA level. The conference benefited all who attended.

Throughout my term as your President, I have made every effort to attend as many county society meetings as possible. My travels across this state and the country have magnified the pride I have always felt for Oklahoma physicians. Each and every county society has accepted the challenge through their participation and dedication at all levels.

Continuing participation is also exemplified by this year's slate of nominees for positions on the OFPR Board of Directors. They are: Bruce C. Stoesser, MD, Tulsa County for Position #7; Clarence Robison, Jr., MD, Oklahoma County for Position #8; Warren L. Felton II, MD, Oklahoma County for Position #11; and Norman A. Cotner, MD, representing the counties outside Tulsa and Oklahoma counties for Position #12.

I have asked you to get involved and to participate and you have answered with a resounding YES! But we must continue . . . We must maintain, at all times, our individual and association goals of promoting medicine in the best interest of our patients and our profession. The excellent OSMA-produced film project depicts the problem. Now we must work together for the solution!

Dr Norman Dunitz, I am proud to present to you an organization which is ready to support you as you take over the office for the finest association of physicians in the country. I know that we will all benefit from your guidance and wisdom during the coming year.

On behalf of my wife, Lucile, and myself, again, thank you all very much.

Respectfully submitted,  
Elvin M. Amen, MD  
President

---

## OSMA House of Delegates

# REPORT OF THE PRESIDENT-ELECT

Fellow physicians and friends of medicine:

Today further verifies the axiom that in spite of what happens, life and activity go on. We are assembled again, in our Oklahoma State Medical Association Annual Meeting, regardless of the buffetings and stresses and problems that medicine as a profession has "enjoyed" over the past few years. And as always, the mantle of the Presidency of our organization is being passed this time from the capable hands of Dr Elvin Amen to another individual. I am that individual who is assuming the Presidency. I thank you for the honor afforded to me and for the privilege of serving that group of people whom I feel are the most dedicated and sincere of any group anywhere, the physicians of the Oklahoma State Medical Association. I hope that I am worthy of the trust and confidence that you have placed in me and that in some

way I can make some little contribution to the progress and viability of the medical profession in Oklahoma. I can only promise you that regardless of what criticisms you may levy toward me at this time next year, the things that will be beyond complaint will be my interest and concern and my willingness to listen and consider any input, suggestions, or recommendations that any of you may have. I do not guarantee to always be right with the decisions that I might make, but I can guarantee that they will be made with sincerity and conscientiousness.

As we look at the role of medicine in the society today, it is rather obvious that there are three main factors which have been present throughout the history of healing professions. These are the factors of technology and scientific knowledge, the relationship between the healer and the ill, and the economic role of the delivery of health care.

Our problems are all related to one of those three entities. Technology and science have climbed to such a degree that no one twenty years ago would even have dreamed what we are doing in this area today. Most of us, at least the older ones, are doing things daily that during our training years we had never heard of and in which we had little, if any, experience. The level in quality of care available to the individual citizen at this point in time is beyond even imagination one short generation ago and appears to be increasing at a progressive rate. We as a profession have done a superb job in this area and we should not be ashamed to take credit for this and be proud of our accomplishments.

However, in the fields of personal relationships with our patients and with the ill public and in the field of the economic role in the practice of medicine, we are being buffeted and attacked from every angle. The problems are certainly there and although extraneous sources do create and multiply many of our troubles, we as individual physicians and as a profession as a whole are not completely lily white or guilt free. Each one of us in this room knows of some instance where the patient was economically gouged by an inordinately high fee; or where the physician attempted something that he was not capable of doing; or where the doctor was really not concerned



**NORMAN L. DUNITZ, MD**  
**OSMA PRESIDENT 1986-87**

about the patient's well-being; or where in some instance or some way the high qualities and high levels of ethics that medicine has strived to obtain were discarded and dropped for a period of time.

We must as a group continue to strive to police ourselves better and to ensure that either those instances or those individuals who do not meet the levels of conscience that are essential to a practitioner of the healing arts be identified, criticized, and hopefully changed in their approach to the suffering ill. Fortunately, I feel that these instances are relatively rare and often arise from misunderstanding and lack of communication rather than willful breach of good care to the patient. But as we face the public we must intensify our efforts to present ourselves as a *concerned, caring* profession who are regulating ourselves and ensuring that anyone providing medical care in our group does so with not only the highest degree of skill available but also with a high degree of conscience and moral value. Your medical societies, both local and state, will continue to try to uphold this pledge.

The second big problem facing us over the next few years is, of course, the problem of liability as it applies to malpractice in the medical profession. The entire concept of tort reform is a major concern to your society as well as to you. It appears at this time that our efforts to date through our coalition working on the legislature in Oklahoma City are going to fall far, far short of obtaining any meaningful relief from the malpractice crisis that we face. Unfortunately, we are facing an almost insurmountable obstacle in that one house of our legislature, particularly our senate, as you all know, is made up of individuals who have an extremely vested interest in seeing that no modifications of the tort system take place. As your president, I will not hesitate calling a spade a spade or a politician a politician. In this state we are in dire need of statesmen and leaders in our governmental organizations, people who will truly be concerned about the welfare of the public and will work to develop such rules as are necessary to ensure this welfare.

But you must remember that this is Oklahoma, the state that so far has not even been able to pass a code of ethics in its legislature; this is the state that recently had the biggest government scandal in the United States with the county commissioner situation that we have gone through and which basically has effected no change in the way business has been carried on it spite of this horrendous scandal; this is the state in which legislators have been indicted and

even sent to prison in the last few years; this is the state where governors have been sent to jail as they stepped off their office dais; this is the state where, not too many years ago, even the supreme court justices were proven to be bought and sold like chattel.

These political failings are obviously degrading and certainly difficult to justify. But this is the atmosphere and this is the background that our legislatures have worked in and hopefully are leaving behind. The vested interests are still strong in some of our politicians — fortunately not all — but as long as these remain, the ability to get a group to think in terms of the well-being of the masses without being influenced by their own personal position is probably still difficult to obtain.

However, our efforts are not complete, and over this next year as a society we will make a strong push to try to alter the tort system in this area. We will need the help of everyone since it is becoming more and more obvious that we must go to the public and to the people. The people, our patients, are our friends. They want and demand quality health care and I think more and more are realizing the necessity of some control on the malpractice issue in order to obtain that quality care. Hopefully, with enough pressure from the public, our congressmen will either be forced to change their posture or even be forced out of office by some challenger who understands and is agreeable to modifications of the liability situation in this state. To aid in these efforts, a rather small assessment of \$150.00 was levied on you. I cannot imagine any physician anywhere in this state being upset with that small amount of money to help fight this battle. This is a *basic* problem regardless of whether you are in class eight with a high risk or class one with no risk. It is a battle of the very role and relationship of the providing of medical help to a patient in our society today. Each of us must support this fight with words, deeds, and with dollars.

The other major problem that is surfacing now, and which will likely become more of an issue over the next year or so, is that of the actual role of the physician. Not as much publicity is present on this at this time, but in the long run I feel this is probably the most important portion of our battle. I am speaking of the pressures of non-medical individuals and groups to take over the determination of what is and what is not an acceptable method of practice and care. I am speaking of the government who insists upon a certain limitation or control of the way certain procedures and treatments are effected. I am speaking of insurance companies who are trying to take



**The Tulsa Convention Center, site of most of this year's business and scientific meetings, is an imposing structure located just across the street from the Excelsior Hotel.**

upon themselves the decision as to which patient needs hospitalization and which does not, as well as for how long. I am speaking of health organizations which are striving to increase monetary profits to their companies without consideration of the impact on the individual patient.

So that you will know where *I* stand on these issues, I have come to grips with the fact that prepaid health care is a living factor in our society. With this comes the necessity of some type of fee control or negotiation of medical fees, hospital fees, and all other costs of the delivery of health care. However, I am ideologically and completely opposed to those systems which reward the physicians or the hospital institution, or any group for withholding care or diminishing the quality of care given to the patient. I will never agree to a situation in which money or economics are the main determinants as to how that individual patient is treated.

These are the three main aspects of the practice

of medicine that exist in 1986 in Oklahoma. Our efforts this coming year, I feel, will of necessity be mainly directed at number two, that is, the liability area. But I believe that the problems of control and decision-making in medical care must be constantly protected. I hope that technology and scientific advancement will continue in their explosive manner, but unfortunately for the very viability of our profession, the other problems are even more vital to the future over the next few decades.

Once again — I feel honored to be your representative. As never before, we need unity of purpose and complete cooperation from all of you — believe me, I will not hesitate to call on you for help.

With the Grace of God — we will again meet together next year, members of a continued strong and most respected profession.

Respectfully submitted,  
Norman L. Dunitz, MD

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# OSMA House of Delegates

## OPENING SESSION

Thursday, May 8, 9:00 AM

### I. Call to Order and Opening Remarks

The Speaker of the House, Larry L. Long, MD, Oklahoma City, called the 80th Annual Session of the OSMA House of Delegates to order at 9:45 AM, May 8, 1986, at the Tulsa Convention Center.

The invocation was delivered by Thomas J. Lowrey, MD, Yukon.

### Special Guest Speaker

Doctor Long introduced newly elected Tulsa Mayor Richard Crawford for his comments, in which he warmly welcomed the physicians to Tulsa and discussed interesting aspects of the recent mayoral race.

### OSMA Film

Doctor Long recognized Dr M. Joe Crosthwait, Chairman of the Council on Professional and Public Relations, to present the OSMA film *Preserving Tradition, Embracing Change*. Doctor Crosthwait explained that this film was the product of the funds allocated in this past year's budget.

### Auxiliary Report

Doctor Long recognized Mrs Mary Ann Deen, outgoing OSMAA President, for her comments. Mrs Deen reported on the numerous auxiliary projects and activities for the past year. She commended the auxiliaries for their dedication and hard work and congratulated the board for its support of the auxiliary.

Mrs Deen then introduced Mrs Kelsey Walters, incoming President for 1986-87, for her comments. Mrs Walters shared some of the goals the OSMAA has for the coming year and announced that this year's theme will be "motivate our volunteers with enthusiasm."



## II. Presentations — AMA-ERF

Mrs Deen recognized Mrs Rosalie Rahe, AMA-ERF Chairman, to present the following checks to the three medical colleges in Oklahoma:

\$32,470.30 to Mark A. Everett, MD, University of Oklahoma College of Medicine, Oklahoma City;

\$4,150.50 to Edward J. Tomsovic, MD, Dean of the University of Oklahoma Tulsa Medical College;

\$2,040.00 was given to Oral Roberts University.

(A representative was not present to receive this amount.)

The total amount was \$38,660.80.

## III. Report of the Credentials Committee

Dr Howard B. Keith, Shattuck, announced that a quorum was present.

## IV. Introductions

Doctor Long introduced those at the head table: Elvin M. Amen, MD, President; Norman L. Dunitz, MD, President-Elect; Michael J. Haugh, MD, Chairman, Board of Trustees; Robert G. Perryman, MD, Vice-Speaker, House of Delegates; Mr David Bickham, OSMA Executive Director; and Mrs Toni Leverett and Mrs Ann McWatters, Recording Secretaries.

Doctor Long then introduced the following special guests: Mr Kevin Walker, AMA Medical Society Relations Officer; Mr Paul Patton, Executive Director, Tulsa County Medical Society; and Mr Rick Ernest, Executive Director, Oklahoma County Medical Society.

Doctor Long introduced the following OSMA Past Presidents who were present: Ed L. Calhoon, MD (1970-71); James B. Eskridge III, MD (1985-86); John A. McIntyre, MD (1982-83); Floyd F. Miller, MD (1980-81); Arnold G. Nelson, MD (1975-76); James B. Pitts, Jr., MD (1981-82); and Orange M. Welborn, MD (1976-77).

Doctor Long then introduced Dr Roger J. Reid, Ardmore, former Speaker of the House of Delegates, and Dr Edward J. Tomsovic, General Chairman of the 1986 Annual Meeting.

## V. Approval of the House of Delegates Minutes

It was moved, seconded, and carried that the House of Delegates accept the Minutes of the 1985 Annual Meeting.

It was then moved, seconded, and carried that the House accept the Minutes of the Special Session of the House on February 9, 1986.

(Facing) Delegates register just inside the main entrance of the Convention Center before going to the House of Delegates. Throughout the meeting, the registration desk serves as a message center and meeting place for delegates and visitors.

## VI. Presentations

### A. H. Robins Award

Doctor Long recognized Dr Michael J. Haugh to present the A. H. Robins Award to this year's recipient, John A. McIntyre, MD, Enid. Doctor McIntyre expressed his appreciation in receiving this award.

### Charlotte S. Leebron Memorial Award

Dr Mark R. Johnson, Editor-in-Chief of the OSMA JOURNAL, presented the Charlotte S. Leebron Memorial Trust Fund Award for the Best Scientific Paper published in the JOURNAL for 1985 to Don P. Wilson, MD. Doctor Wilson and his co-authors, Nancy J. Carpenter, PhD, and John H. Holcombe, MD, wrote the paper "Turner Syndrome: Clinical Investigations and Review."

## VII. Remarks of the Speaker

Doctor Long appointed the following committees to assist in the conduct of the meeting:

### *Parliamentarian*

J. B. Eskridge III, MD, Oklahoma City

### *Credentials Committee*

Howard B. Keith, MD, Shattuck, Chairman

Jack J. Beller, MD, Norman

William C. Stone, MD, Tulsa

### *Tellers*

George A. Shelton, Jr., MD, Norman, Chairman

Richard J. Boatsman, MD, Lawton

Cathy Conley, MS II, Oklahoma City

### *Sergeant-At-Arms*

Norman A. Cotner, MD, Grove

### *Reference Committee I*

Mary Anne McCaffree, MD, Oklahoma City, Chairman

James D. Brashear, MD, Norman

Tim S. Caldwell, MD, Tulsa

Daniel H. Carmichael, MD, Oklahoma City

William E. Harrison, Jr., MD, Tulsa

James R. Rhymer, MD, Clinton

Stephen Tkach, MD, Oklahoma City

### *Reference Committee II*

Lee N. Newcomer, MD, Tulsa, Chairman

Stephen E. Acker, MD, Oklahoma City

Billy Dale Dotter, MD, Okeene

F. Daniel Duffy, MD, Tulsa

Jeffrey S. Lester, MD, Mangum

Ambrosio Solano, Jr., MD, Owasso

Roland A. Walters, MD, Oklahoma City

### *Reference Committee III*

R. Kern Jackson, MD, McAlester, Chairman

Schaes L. Atkinson, MD, Oklahoma City

Curtis O. Bohlman, MD, Watonga

Philip C. Bryan, MD, Miami

Jerry L. Puls, MD, Tulsa

Rollie E. Rhodes, Jr., MD, Tulsa

Rebecca Goen Tisdal, MD, Oklahoma City

Richard L. Winters, MD, Poteau

Doctor Long also advised the Delegates to wear their badges at all times. He noted that immediately following the OSMA President's address there will be a 10-minute recess for the county medical society caucuses to prepare for nominations for the various association offices.

Doctor Long then announced the following changes for the House of Delegates: There has been a change in authorship for Resolutions No. 4, 6, and 7 in Reference Committee II and No. 8 in Reference Committee III — the authors are now designated as Drs Arnold G. Nelson and Kenneth W. Whittington; Late Resolution No. 24 was passed on by the Board of Trustees and has been assigned to Reference Committee I; Resolution No. 11 has been moved from Reference Committee II to Reference Committee III; Resolution No. 5 has been withdrawn.

### VIII. President's Report

Doctor Elvin M. Amen, outgoing OSMA President, delivered his final address to the House of Delegates. He commented on the involvement and participation achieved this year at all levels of association activity. Doctor Amen then reviewed various activities of this past year, including trips to Washington, DC, to meet with the Oklahoma Delegation and the work done to accomplish tort reform measures through the Return to Reason coalition and at the State Capitol. Doctor Amen pledged support to Dr Norman L. Dunitz, incoming President.

[The complete text of Doctor Amen's report appears on page 493.]

### IX. Recess

At 10:50 AM the House recessed to allow the county medical societies to caucus. The House reconvened at 11:05 AM.

### X. Nominations for Elections

Doctor Long announced only one seconding speech would be allowed per nomination.

He declared the House open for nomination for the position of *President-Elect* (one-year term of office).

M. Joe Crosthwait, MD, Midwest City, was nominated by Gary W. Rahe, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Vice-President* (one-year term of office).

Ray V. McIntyre, MD, Kingfisher, was nominated by Stephen R. Arthurs, MD. The nomination was seconded.

Francis W. Hollingsworth, MD, El Reno, was nominated by Thomas J. Lowrey, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Speaker, House of Delegates* (two-year term of office).

Larry L. Long, MD, Oklahoma City, was nominated by James B. Pitts, Jr., MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Vice-Speaker, House of Delegates* (two-year term of office).

Robert G. Perryman, MD, Tulsa, was nominated by Boyd O. Whitlock, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Delegate to the AMA (Position I)*.

M. Joe Crosthwait, MD, Midwest City, was nominated by Perry A. Lambird, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Delegate to the AMA (Position II)*.

Floyd F. Miller, MD, Tulsa, was nominated by Rollie R. Rhodes, Jr., MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Delegate to the AMA (Position IV)*.

Perry A. Lambird, MD, Oklahoma City, was nominated by William O. Coleman, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position I)*.

John R. Alexander, MD, Tulsa, was nominated by Jerry L. Puls, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position IV)*.

John A. McIntyre, MD, Enid, was nominated by Donald C. Karns, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District III)*.

James S. Gerber, MD, Okarche, was nominated by Stephen R. Arthurs, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.



**New Tulsa Mayor Richard Crawford greets delegates at the Opening Session, welcoming the OSMA to his city.**

Nominations were declared open for the position of *Trustee (District VI)*.

Gary F. Strebel, MD, Oklahoma City, was nominated by John A. Blaschke, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District VI)*.

Perry A. Lambird, MD, Oklahoma City, was nominated by Raymond L. Cornelison, Jr., MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Trustee (District VI)*.

James D. Funnell, MD, Oklahoma City, was nominated by Roland A. Walters, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District VI)*.

Gary W. Rahe, MD, Oklahoma City, was nominated by James D. Funnell, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Trustee (District VII)*.

Eldon V. Gibson, MD, Shawnee, was nominated by Leon D. Combs, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Alternate Trustee (District VII)*.

David A. Ronk, MD, Norman, was nominated by Leon D. Combs, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the position of *Trustees and Alternate Trustees (District VIII)*.

Jerry L. Puls, MD, Tulsa; Rollie E. Rhodes, MD, Tulsa; and Eric L. Westerman, MD, Tulsa, were nominated by Walter H. Gary, MD. The nominations were seconded.

Donald F. Mauritsen, MD, Tulsa; Edward W. Jenkins, MD, Tulsa; and Theodore J. Brickner, MD, Tulsa, were nominated by Walter H. Gary, MD. The nominations were seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the positions of *Trustee and Alternate Trustee (District IX)*.

Thomas C. Alexander, MD, Okmulgee, was nominated by himself.

W. Kermit Baker II, MD, Muskogee, was nominated by Thomas C. Alexander, MD.

The above nominations were seconded.

There being no other nominations, the nominations were declared closed.

Nominations were declared open for the positions of *Trustee and Alternate Trustee (District X)*.

Richard L. Winters, MD, Poteau, was nominated by R. Kern Jackson, MD. The nomination was seconded.

Bruce S. Hinkley, MD, McAlester, MD, was nominated by R. Kern Jackson, MD. The nomination was seconded.

There being no other nominations, the nominations were declared closed.

Nominations for the PLICO Board of Directors (three-year term) were held at this time. Doctor Long announced the Board of Trustees heard nomination recommendations, approved them, and has forwarded them to the House of Delegates for consideration. The slate of nominees is as follows:

John R. Alexander, MD, Tulsa, Advisory Member

Ed L. Calhoon, MD, Beaver

Billy R. Goetzinger, MD, Oklahoma City

Floyd F. Miller, MD, Tulsa

Ray V. McIntyre, MD, Kingfisher

At this time, Doctor Long turned the meeting over to Robert G. Perryman, MD, Vice-Speaker of the House of Delegates.

### XI. Report of the Chairman of the Board

Michael J. Haugh, MD, referred to his report. He noted the Board had its Annual Meeting on Wednesday, May 7. The Supplemental Report was distributed to the House. (A copy of the Supplemental Report is made a part of the Official Minutes in the OSMA JOURNAL.)

### XII. Report of the Secretary-Treasurer

Raymond L. Cornelison, Jr., MD, referred to his report included in the handbooks. He noted that the 1985-86 projected deficit of \$100,000 had been reduced to \$80,000. He reviewed OSMA assets and discussed revenues and expenses.

Doctor Cornelison explained the need for a dues increase to lower budget deficits but noted that plans will be made instead to decrease costs in OSMA expenses. (A copy of the Secretary-Treasurer's Report is included in the Official Minutes in the OSMA JOURNAL.)

### XIII. Presentation of Business to Come Before the House

Doctor Perryman advised the Delegates to pick up the handouts at the side of the room. No other business will be considered at the Closing Session.

### XIV. Other Business

Doctor Perryman informed the Delegates that the Closing Session will be held in the Windsor Room at the Excelsior Hotel at 12:30 PM, Saturday, May 10.

### XV. Necrology Report

Doctor Perryman read the Necrology Report, after which a moment of silence was observed. (A copy of this report is attached and made a part of these minutes.)

#### 1985-86 Necrology Report

Meredith M. Appleton, MD  
Carl H. Bailey, MD  
Forest Reed Brown, MD  
Maurice P. Capehart, MD  
Murray M. Cash, MD  
John R. Cotteral, MD  
Roy W. Donaghe, MD  
Francis Michael Duffy, MD  
Michael Wayne Durbin, MD  
William Hampton Garnier, MD  
Adam Luis Gorena, Jr., MD  
Minard Friedberg Jacobs, MD  
Hannah B. Karam, MD  
Robert Lewis Kendall, MD  
Ernest S. Kerekes, MD  
Marion K. Ledbetter, MD

Edward LeRoy Leonard, MD  
Bernice Eugenie McCain, MD  
L. Chester McHenry, MD  
William C. Moore, MD  
James Floyd Moorman, MD  
Franklin Jesse Nelson, MD  
Robert Alan Northrup, MD  
Charles Frederick Obermann, MD  
Seigul J. Polk, MD  
Alexander Poston, MD  
Robert Ray Rupp, MD  
John W. Shackelford, MD  
Hugh Burns Spencer, MD  
Jesse Ray Waltrip, MD  
Oscar R. White, MD



The furrowed brow "comes with the territory." Raymond L. Cornelison, Jr., MD, OSMA secretary-treasurer, delivers his report to the House of Delegates during the Opening Session.

### XVI. Recess

Doctor Perryman noted that the Reference Committees will meet once the Opening Session is recessed. He noted that Reference Committee I will meet in Room 2-G, Reference Committee II in Room 2-A, and Reference Committee III in Room 2-C, all at the Convention Center. He encouraged the Delegates to attend the Reference Committees.

The Opening Session of the House of Delegates recessed at 11:40 AM.

Recorded by Toni Leverett and Ann McWatters

(Facing) Mary Kay McPhee, president of the AMA Auxiliary, came from Kansas City to address the House of Delegates. Here she announces that Mary Ann Deen, Ada, OSMAA president 1985-86, has been appointed National Membership Committee Representative, and OSMA Auxilian Sherry Strebel, Oklahoma City, has been appointed National Legislative Chairman of the AMA Auxiliary.

# OSMA House of Delegates

## CLOSING SESSION

Saturday, May 10, 12:30 PM

### I. Call to Order and Introductions

The Closing Session of the 80th Annual Meeting of the House of Delegates was called to order by Speaker Larry L. Long, MD, Oklahoma City, at 12:45 PM in the Windsor Room at the Radisson Excelsior Hotel, Tulsa, Oklahoma.

### II. Report of the Credentials Committee

Credentials Committee Chairman Jack J. Beller, MD, Norman, announced that a quorum was present.

### III. Special Item

Doctor Long announced that the House is technically in recess, and a housekeeping chore needs to be done. He noted that during the nomination process at the Opening Session, the Chair was not advised to solicit nominations for AMA Alternate Delegate Position II.

It was moved, seconded, and carried that nominations be reopened to allow for the AMA Alternate Delegate (Position II) slot.

Nominations were declared open for the position of *Alternate Delegate to the AMA (Position II)*.

William O. Coleman, MD, Oklahoma City, was nominated by Gary W. Rahe, MD.

There being no other nominations, the nominations were declared closed.

### IV. Invocation

Mrs Mary Ann Deen, outgoing Auxiliary President, delivered the invocation.

### V. Introductions

A. Doctor Long introduced J. John Coury, MD, President-Elect of the American Medical Association, a general surgeon from Port Huron, Michigan. Doctor Coury addressed the members of the House and discussed what the AMA is and many of the services it offers. He also touched upon the physician oversupply and the professional liability crisis. Doctor Coury then urged all to become involved community citizens. Doctor Long thanked Doctor Coury for his remarks.

B. Doctor Long then introduced Mrs Mary Kay McPhee, President of the AMA Auxiliary, from Kansas City, Missouri, to make a short presentation to the House. Mrs McPhee announced that Mrs Mary Ann Deen has been appointed National Membership Committee Representative, and Mrs Sherry Strebel has been appointed National Legislative Chairman of the AMA Auxiliary. Mrs McPhee then discussed the various AMA Auxiliary activities. Doctor Long thanked Mrs McPhee for her remarks.

C. Doctor Long introduced Wilson D. Steen, PhD, to make the following presentations:

Certificates were presented to Drs Steve Silverstein and Paula Mason Camp for their outstanding work in developing the Oklahoma State Medical Association Student Section. John Buie accepted the award for Silverstein.

Doctor Steen then presented a plaque listing the charter members of the Medical Student Section and announced that the plaque will be mounted in a prominent place at the University of Oklahoma College of Medicine.



D. Dr Mark R. Johnson, JOURNAL Editor-in-Chief, was recognized to present to Dr Elvin M. Amen, outgoing President, a bound volume of JOURNALS which were published during his term for 1985-86. Doctor Amen expressed his appreciation.

#### VI. Remarks of the President-Elect

Dr Norman L. Dunitz presented his report to the House. [The complete text of Doctor Dunitz's report appears on page 495.]

#### VII. Annual PLICO Shareholders' Meeting

Doctor Long declared the Annual Shareholders' Meeting of PLICO was in session, and introduced John A. McIntyre, MD, to present a brief report. (A copy of the PLICO Report is made a part of the official minutes in the OSMA JOURNAL.)

Doctor Long then declared the PLICO Annual Shareholders' Meeting closed.

#### VIII. Elections

Doctor Long explained that there is one contested position, that of Vice-President, and ballots have been prepared. Francis W. Hollingsworth, MD, El Reno, and Ray V. McIntyre, MD, Kingfisher, have been nominated. Ballots were distributed for the vote. Doctor Long noted that once the tellers have tallied the vote, the winner would be announced.

Doctor Long appointed as tellers Robert J. Weedn, MD, Duncan, and MS Lana Oglesbee, Oklahoma City, to assist Dr G. A. Shelton, Jr., Norman, Teller Chairman.

Doctor Long then reviewed the following nominations for election:

- M. Joe Crosthwait, MD, Midwest City — *President-Elect*
- Larry L. Long, MD, Oklahoma City — *Speaker, House of Delegates*
- Robert G. Perryman, MD, Tulsa — *Vice-Speaker, House of Delegates*
- M. Joe Crosthwait, MD, Midwest City — *AMA Delegate (Position I)*
- Floyd F. Miller, MD, Tulsa — *AMA Delegate (Position II)*
- Perry A. Lambird, MD, Oklahoma City — *AMA Delegate (Position IV)*
- John R. Alexander, MD, Tulsa — *AMA Alternate Delegate (Position I)*
- William O. Coleman, MD, Oklahoma City — *AMA Alternate Delegate (Position II)*
- John A. McIntyre, MD, Enid — *AMA Alternate Delegate (Position IV)*

*Trustee District III:* Garfield, Grant, Kingfisher, and Logan Counties

Alternate: James S. Gerber, MD, Okarche

*Trustee District VI:* Oklahoma County

Trustee: Gary F. Strebel, MD, Oklahoma City

Alternate: Perry A. Lambird, MD, Oklahoma City

Trustee: James D. Funnell, MD, Oklahoma City

Alternate: Gary W. Rahe, MD, Oklahoma City

*Trustee District VII:* Cleveland, Creek, Lincoln, Okfuskee, Pottawatomie and McClain Counties

Trustee: Eldon V. Gibson, MD, Shawnee

Alternate: David A. Ronk, MD, Norman

*Trustee District VIII:* Tulsa County

Trustee: Jerry L. Puls, MD, Tulsa

Alternate: Donald L. Mauritsen, MD, Tulsa

Trustee: Rollie R. Rhodes, Jr., MD, Tulsa

Alternate: Edward W. Jenkins, MD, Tulsa

Trustee: Eric L. Westerman, MD, Tulsa

Alternate: Theodore J. Brickner, Jr., MD

*Trustee District IX:* Adair, Cherokee, McIntosh, Muskogee, Okmulgee, Sequoyah and Wagoner Counties

Trustee: Thomas C. Alexander, MD, Okmulgee

Alternate: W. Kermit Baker II, MD, Muskogee

*Trustee District X:* Haskell, Hughes, Latimer, LeFlore, Pittsburg and Seminole Counties

Trustee: Richard L. Winters, MD, Poteau

Alternate: Bruce S. Hinkley, MD, McAlester

#### PLICO Board of Directors:

John R. Alexander, MD, Tulsa, Advisory Board Member

Ed L. Calhoon, MD, Beaver

Billy R. Goetzinger, MD, Oklahoma City

Floyd F. Miller, MD, Tulsa

Ray V. McIntyre, MD, Kingfisher

There being no objection from the floor, Doctor Long declared the slate of nominees (as noted above) duly elected and congratulated the new officers and trustees.

#### IX. Reference Committee Reports

Doctor Long stated the Reference Committee Reports would be governed by Roberts Rules of Order. A Delegate can speak once for or against a question. Variation from that will be at the Chair's discretion. He asked that each Delegate state his name and county medical society when speaking before the House. Doctor Long stated that a recommendation by a Reference Committee is automatically introduced as a motion and does not require a second.

The Reference Committee Reports considered by the House are attached and made a part of the official minutes included in the July 1986 issue of the OSMA JOURNAL.



In the House of Delegates, Wilson D. Steen, PhD, Oklahoma City, displays a plaque listing the charter members of the newly formed OSMA Student Section. The plaque will be displayed in a prominent place at the University of Oklahoma College of Medicine. He also commended Dr Paula Mason Camp, standing to his left, and Dr Steve Silverstein for their work in organizing the Student Section.

### Report of Reference Committee I

Presented by Mary Anne McCaffree, MD, Oklahoma City

Reference Committee I approved the following items without amendment:

*Item 1. Report of the Board of Trustees.*

*Item 2. Supplemental Report of the Board of Trustees.*

The Reference Committee suggested that the OSMA Board of Trustees publicize the names of the nominees for the PLICO Board of Directors in advance of the Annual Meeting of the House of Delegates.

Doctor Long recognized Doctor Dunitz, who noted that the Executive Committee and the Board of Trustees voted to not have a dues increase for 1987 and instead find ways to attract income and reduce expenditures. Doctor Dunitz moved that the Board of Trustees and the OSMA executive staff reduce association expenses across the board by 5 percent. The motion was seconded and carried.

*Item 3. Report of the Secretary-Treasurer.*

*Item 4. Report of the Budget and Audit Committee.*

*Item 5. Report of the Council on Long-Range Planning and Development.*

*Item 6. Report of the Constitution and Bylaws Committee.* The Reference Committee reminded the House that by adopting the Constitution and Bylaws Committee Report, the Constitution of the OSMA is amended to provide for the seating of voting delegates to represent the Hospital Medical Staff Section, the Resident Physician Section, and the Medical Student Section.

*Item 7. Report of the Physicians Liability Insurance Company.*

*Item 8. Report of the Return to Reason Coalition.*

*Item 9. Report of the OSMA Auxiliary.*

Reference Committee I approved the following items as amended:

*Item 11. Resolution 15 — Ending Tobacco Supports.* The Reference Committee recommended that Resolution 15 be adopted with the following amendment of the Resolve paragraph beginning on Line 19, to read as follows:

*"Resolved,* That the Oklahoma Delegates to the AMA House of Delegates introduce a resolution in that body asking the AMA Board of Trustees to inform all appropriate national medical-oriented organizations of the importance of Resolution 77 (A-85) which expresses the AMA's opposition to the tobacco industry, and further, urge and challenge other organizations to take similar action."

*Item 14. Resolution 18 — Limiting Terms of AMA Delegates.* The Reference Committee recommended that Resolution 18 be adopted with the following amendment:

On Line 16 the word *consecutive* should be inserted after the figure 6 in parentheses and before the phrase *two-year terms*.

*Item 15. Resolution 21 — Committee on Medical Ethics and Competency.* The Reference Committee recommended that Resolution 21 be adopted with the following amendment:

On Line 17, Page 2, the sentence beginning with the word *Further* is amended to read, "Further, the Committee shall investigate complaints or allegations of the possible loss or absence of an OSMA member's medical, clinical, scientific, or mental competency, or physical competency, as the latter shall affect the practice of medicine."

Subsection (e), Line 21, Page 3, is amended to read, "In cases of impaired competency or for statutory reasons, to report same promptly to the Board of Medical Examiners for investigation and appropriate action, and/or to the Physician Recovery Committee if appropriate."

Reference Committee I rejected the following items:

*Item 10. Resolution 2 — Physician-Attorney Involvement.* The members of the Reference Committee endorsed the concerns expressed in this resolution but noted that the choice of legal counsel should be made by those who best know the capabilities of the attorneys.

A Substitute Resolution was introduced for consideration by the House by Dr William O. Coleman, as follows:

*"Resolved, That the OSMA communicate to the Board of Directors of PLICO the request of many of its physician policyholders, that PLICO encourage the defense attorneys it employs to utilize qualified licensed physician-attorneys, when specifically requested by the sued physician."*

Discussion took place. A vote was taken, and the Substitute Resolution failed.

Consideration went back to the motion to not adopt Resolution 2. A vote was taken, and the motion carried.

*Item 11. Resolution 13 — Mandatory Outpatient T & As.*

*Item 12. Resolution 14 — Mandatory Outpatient Surgery for Hernia Repair.*

*Item 16. Resolution 24 — Revocation of Resident Assessment.* The Reference Committee recognized the financial responsibilities that accompany residency training; however, the amount in question is only \$300, but may be paid in two yearly installments of only \$150 each.

At this time three new Delegates were seated: David Russell, MD, Enid, for the Hospital Medical Staff Section, and Medical Students Lana Oglesbee and Cathy Conley for the Student Section.

## Report of Reference Committee II Presented by Lee N. Newcomer, MD, Tulsa

Reference Committee II approved the following items without amendment:

*Item 1. Report of the President.* The Reference Committee conveyed its most sincere gratitude and appreciation to Elvin M. Amen, MD, for his excellent leadership throughout the past year.

*Item 2. Report of the Council on Professional and Public Relations.* The Reference Committee commended M. Joe Crosthwait, MD, and Mike Sulzycki, OSMA Associate Director, for the outstanding production of the film *Preserving Tradition, Embracing Change*. The Reference Committee also recommended that the council consider additional films in the future at the discretion of the Board of Trustees.

*Item 3. Progress Report, Oklahoma State Medical Association Medical Student Program.* The Reference Committee commended Wilson D. Steen, PhD, for the work he has done to organize the medical student section of the OSMA.

*Item 4. Report of the Council on Public and Mental Health.* The Reference Committee expressed its gratitude for the manner in which the Council carried out its assigned duties.

*Item 5. Report of the Council on Medical Education.* The Reference Committee expressed its appreciation to the Council for effectively carrying out its assigned duties.

*Item 6. Report of the Council on Medical Services.* The Reference Committee extended special commendation to John A. Blaschke, MD, Council Chairman, for his exceptional service.



The room was packed at the Closing Session of the House of Delegates, held in the Excelsior Hotel on Saturday.

*Item 7. Report of the Section on Hospital Medical Staffs.* The Reference Committee noted the formation of the new Hospital Medical Staff Section, election of officers and a new agenda.

*Item 9. Report of the JOURNAL of the Oklahoma State Medical Association.* The Reference Committee noted the appointment of Donald L. Brawner, MD, as an Editor of the JOURNAL, replacing Robert G. Tompkins, MD. The Reference Committee expressed its appreciation to Doctor Tompkins for his many years of dedicated service on the Editorial Board.

*Item 11. Resolution 3 — Beef and Coronary Heart Disease.*

*Item 15. Resolution 9 — Non-Smokers Inhalation.*

*Item 18. Resolution 17 — Smokeless Tobacco Education and Prohibiting Use of All Tobacco Products in Schools.*

*Item 19. Resolution 19 — Governor's Task Force on Perinatal Care.*

*Item 20. Resolution 22 — Medical Health Officers.*

*Item 21. Resolution 23 — Crisis Intervention Center.*

Reference Committee II approved the following items as amended:

*Item 10. Resolution 1 — National Catastrophic Medical Insurance.* The concept of medical catastrophic insurance has already been introduced before the AMA; therefore, lines 18-20 on page 1 should be deleted.

*Item 12. Resolution 4 — Medical School Admissions Reduction.* The Reference Committee recommends the deletion of lines 6 and 7; the last word on line 16, and lines 17 and 18:

*"Resolved, That the Oklahoma State Medical Association recommend that the Oklahoma State Legislature amend present statutes to provide for a 15% reduction in enrollment of medical and osteopathic students on a pro rata basis: and be it further*

*"Resolved, That the OSMA recommend to the Oklahoma State Legislature and to the University of Oklahoma Health Sciences Center that an immediate suspension be placed on all admissions to the Physicians' Assistant Training Program; and be it further*

*"Resolved, That the OSMA recommend that the Oklahoma State Legislature introduce legislation repealing the Physicians' Assistant Training Act."*

Reference Committee II rejected the following items:

*Item 13. Resolution 6 — Foreign Medical Graduates in Residency Programs.* The Reference Committee recommended that the following Substitute Resolution be adopted in lieu of Resolution 6:

*"Resolved, That the Oklahoma State Medical Association and the American Medical Association urge residency programs in Oklahoma to employ only graduates of LCME-approved medical schools or graduates of foreign medical schools whose training is subsidized by their respective countries and who are required to return to those countries upon completion of their residency training; and be it further*

*"Resolved, That the United States Congress be urged to repeal the Desirable Alien Act; and be it further*

*"Resolved, That the Oklahoma State Board of Medical Examiners be apprised of this resolution."*



Timothy Keating, Baltimore, professional relations advisor for the Health Care Financing Administration (HCFA), addresses the General Session on Thursday. His presentation was entitled "Federal Reimbursement for Physicians: The Present and the Future."

*Item 14. Resolution 7 — Family Physicians' Second Opinions.* The Reference Committee recommended that the following Substitute Resolution be adopted in lieu of Resolution 7:

*"Resolved, That the OSMA encourage third-party payors and other interested parties to recognize the ability of Primary Care Physicians to render second opinions regarding the necessity of primary care diagnostic or therapeutic procedures."*

*Item 16. Resolution 10 — Primary Care Physicians.* The Reference Committee recommended that the following Substitute Resolution be adopted in lieu of Resolution 10:

*"Resolved, That the Oklahoma State Medical Association support changes in the medical education system that will create doctors that will be able to locate in areas of Oklahoma that need physicians, including but not limited to:*

1. A primary-care oriented curriculum from the first day of medical school;
2. More medical education programs (student and resident clerkships) in the less populated areas of the state;
3. Consideration of the resident spending at least part of the third year of residency in a location suitable for his or her eventual practice location;
4. Encourage locum tenens in rural Oklahoma practices."

*Item 17. Resolution 12 — Cutbacks in Funding in Perinatal Care.* The Reference Committee agreed with this resolution but felt that it was redundant with Resolution 19 — Governor's Task Force on Perinatal Care.

Doctor Long turned the meeting over to Robert G. Perryman, MD, Vice-Speaker.

### Report of Reference Committee III

Presented by R. Kern Jackson, MD, McAlester

Reference Committee III approved the following items without amendment:

*Item 1. Report of the Council on Governmental Activities.* The Reference Committee heard a well-organized report from Perry A. Lambird, MD, Council Chairman, concerning the status of federal legislation and national developments as they pertain to the medical profession.

*Item 2. Report of the Council on State Legislation.* The Reference Committee heard from the OSMA Director of State Legislation, Otie Ann Carr, regarding the numerous legislative bills considered by this Council.

*Item 3. Report of the Council on Member Services.* Dr William O. Coleman, Chairman of the Council on Member Services, reviewed for the Reference Committee the numerous responsibilities charged to this Council. The Reference Committee congratulated Doctor Coleman and the members of his Council for their in-depth work and maintenance of the underwriting program for professional liability insurance through PLICO.

*Item 4. Report of the Oklahoma Medical Political Action Committee.* The Reference Committee congratulated the dedication of Dr Larry L. Long, Robert W. Baker, and Ann McWatters for their devotion in an area that deserves this association's entire support both financially and politically.

*Item 5. Report of the Physician Recovery Committee.* The Reference Committee congratulated Program Director, J. Darrel Smith, MD, for a job well done.

*Item 20. Resolution 20 — OSMA Annual Meeting.*

Reference Committee III approved the following item as amended:

*Item 7. Resolution 11 — Mandatory Assessment.* The Reference Committee recommended amending line 17 following the word *assignment* by deleting the language *including but not limited to* and inserting the language *which might include the following*.

Resolution 11 asks that the OSMA take whatever means necessary to prevent mandatory assignment by various means. Although the Committee wholeheartedly endorsed the opposition to mandatory assignment, the Committee felt that the resolve was too stringent.

Reference Committee III rejected the following items:

*Item 6. Resolution 8 — Opposition to Dual Fees.* Resolu-

tion 8 is a poorly worded reiteration of existing OSMA policy. The Reference Committee questioned the value of an effort to inform all third-party payors of association policy.

*Item 8. Resolution 16 — Formation of a Non-Profit HMO by OSMA.* The Reference Committee discussed this resolution in great detail and recommended that Resolution 16 not be adopted. The competitive nature of HMOs, IPAs, and similar forms of delivery systems requires stringent utilization review programs that may exclude some physician members because of practice preference or patterns. Such action would have the effect of placing the association member in competition with his own association. Necessary disciplinary actions to preserve the financial integrity of the HMO, IPA, etc., based on economic consideration could conflict with the association's traditional role of evaluating clinical competency and medical judgment. In addition, the Reference Committee noted its awareness that there are a number of physician-sponsored HMOs.

Doctor Perryman expressed thanks to all the members of the reference committees for their time and effort spent.

### X. Other Business

Doctor Perryman announced that Ray V. McIntyre, MD, Kingfisher, has been elected as Vice-President.

Doctor Perryman noted that the PLICO Forum will meet in the Philbrook Room upon adjournment of the House.

He then congratulated Frank A. Clingan, MD, Chairman of the Scientific Program Committee, and Edward J. Tomsovic, MD, General Chairman of the 1986 Annual Meeting. Doctor Perryman also expressed appreciation to everyone for a successful Annual Meeting.

Doctor Perryman announced an addition to the Necrology Report, John W. Shackelford, MD, who had been living in Holly Springs, Mississippi, since retiring from practice in Oklahoma.

### XI. Adjournment

It was moved, seconded, and carried that the Closing Session of the 80th Meeting of the House of Delegates adjourn. The House of Delegates adjourned at 2:55 PM.

Recorded by Toni K. Leverett and Susan Meeks, Recording Secretaries.

# OSMA House of Delegates

## RESOLUTIONS

### RESOLUTION 1

(Adopted As Amended)

Introduced by: Cleveland-McClain County Medical Society  
Subject: **National Catastrophic Medical Insurance**  
Referred to: Reference Committee II

WHEREAS, Medical expenses related to catastrophic illness or accident may be overwhelming and cause permanent financial debility of patients and families; and

WHEREAS, Present mechanisms for dealing with expenses associated with such catastrophes require total depletion of the family resources prior to financial aid or require tort actions on the part of the patient or family; and

WHEREAS, It seems humane and self-evident that a caring society should prevent financial catastrophe from further devastating those families suffering from the physical and emotional burden of medical catastrophes; now therefore be it

*Resolved*, That the House of Delegates support the concept of medical catastrophic insurance; and be it further

*Resolved*, That the House of Delegates notify by written resolution all United States Congressmen and Senators from the State of Oklahoma of this support; ~~and be it further~~

~~*Resolved*, That a resolution in support of the concept of medical catastrophic insurance be introduced before the American Medical Association House of Delegates.~~

### RESOLUTION 2

(Not Adopted)

Introduced by: Cleveland-McClain County Medical Society  
Subject: **Physician-Attorney Involvement in the Defense of Medical Malpractice**  
Referred to: Reference Committee I

WHEREAS, The so-called "malpractice crisis" is in reality a liability crisis, created by unrealistic expectations on the part of attorneys, judges, and lay juries; and

WHEREAS, At least several Oklahoma practicing physicians have undertaken to complete legal education and licensure for the purpose of serving as attorneys assisting in the defense of their physician colleagues against accusations of medical malpractice; and

WHEREAS, The major legal firms in Oklahoma specializing in the defense of physicians accused of medical malpractice have consistently communicated to Oklahoma's physician-attorneys (either directly or indirectly) that they do not welcome physician-attorneys as partners in the defense of their colleagues; and

WHEREAS, The Physicians Liability Insurance Company (PLICO) determines which legal firms will provide defense to the majority of Oklahoma physicians accused of medical malpractice, and in turn employs such firms; and



Soft drinks and hot sandwiches, available in the Exhibit Hall at noon each day, are a welcome sight to these harried delegates, caught between a late-running Opening Session and their about-to-convene reference committee meetings.

## RESOLUTIONS

WHEREAS, The Oklahoma State Medical Association believes that the involvement of qualified physician-attorneys in the defense of physicians against accusations of medical malpractice would be beneficial; now therefore be it

*Resolved*, That the Oklahoma State Medical Association will communicate to the Board of Directors of PLICO its desire that PLICO encourage the defense firms it employs on behalf of Oklahoma physicians to hire qualified physician-attorneys, when possible, to assist in, and to develop practical skill and expertise in, the defense of Oklahoma physicians accused of medical malpractice.

### SUBSTITUTE RESOLUTION 2

(Not Adopted)

*Resolved*, That the OSMA communicate to the Board of Directors of PLICO the request of many of its physician policy holders, that PLICO encourage the defense attorneys it employs to utilize qualified licensed physician-attorneys, when specifically requested by the sued physician.

### RESOLUTION 3

(Adopted)

Introduced by: Ed L. Calhoon, MD, John A. McIntyre, MD  
Scott Hendren, MD, Wiley T. McCollum, MD  
and L. V. Baker, Jr., MD  
Subject: **Beef and Coronary Heart Disease**  
Referred to: Reference Committee II

WHEREAS, Lean beef is a safe and nutritious food and a major source of high quality protein, iron, zinc, B-vitamins and other trace minerals; and

WHEREAS, The fat of lean beef is only saturated fatty acid and not a saturated fat, which reacts much differently when ingested; and

WHEREAS, Beef fat consists of slightly less than half saturated fatty acids, the rest being mainly monounsaturated fatty acids (oleic and palmitoleic), which are believed to lower the LDL/HDL ratio, and small amounts of polyunsaturated fatty acids, both of which are believed to lower the blood serum cholesterol when substituted for saturated fat; and

WHEREAS, A 3-ounce serving of lean beef supplies only 70 to 80 milligrams of cholesterol, similar to that in chicken and many fish; the average human makes from 1000 to 2000 mg. of cholesterol daily in his normal metabolism; and

WHEREAS, Dietary advice about the intake of lean beef and related foods of animal origin must be put into context with other more important "risk factors" for coronary heart disease; these are smoking, inherited genetic dispositions, high blood pressure, obesity, and diabetes; and

WHEREAS, There is considerable Peer Review Research in the best of Nutritional and Medical Literature supporting Lean Red Meat as a safe and nutritious food; and

WHEREAS, There is a plethora of misinformation about lean beef in the Mass Media today; now therefore be it

*Resolved*, That we as a medical profession believe that lean beef, when part of a diet of a variety of foods, is valuable and much needed in the American diet.



The topic is "Andrology Laboratory Analysis in the Infertile Couple" as J. Edward Wortham, PhD, makes his point. Dr Wortham is an associate professor of obstetrics and gynecology at OU Tulsa Medical Center.

### RESOLUTION 4

(Adopted As Amended)

Introduced by: Arnold G. Nelson, MD, and  
Kenneth W. Whittington, MD  
Subject: **Medical School Admissions Reduction**  
Referred to: Reference Committee II

WHEREAS, There is an overabundance of physicians in certain specialties and geographical areas over Oklahoma; and

WHEREAS, Our state economy is depressed, creating tax problems for industry and individual taxpayers alike; and

~~WHEREAS, These same taxpayers should not bear the burden of subsidizing education for those outside the state; and~~

WHEREAS, A real and meaningful reduction in graduate physicians and state expenditures for physician training is not possible without a reduction in enrollment in all state funded schools engaged in the training of undergraduate physicians; now therefore be it

*Resolved*, That the Oklahoma State Medical Association recommend that the Oklahoma State Legislature amend present statutes to provide for a 15% reduction in enrollment of medical and osteopathic students on a pro rata basis, ~~with the first reductions being made in the number of out-of-state students accepted; and be it further~~

~~*Resolved*, That the OSMA recommend to the Oklahoma State Legislature and to the University of Oklahoma Health Sciences Center that an immediate suspension be placed on all admissions to the Physicians' Assistant Training Program; and be it further~~

~~*Resolved*, That the OSMA recommend that the Oklahoma State Legislature introduce legislation repealing the Physicians' Assistant Training Act.~~

## RESOLUTION 5

(Withdrawn)

Introduced by: Oklahoma Academy of Family Physicians  
Subject: **Definition of Primary Physician**  
Referred to: Reference Committee II

WHEREAS, The term *primary physician* was chosen by the Citizen's Commission on Graduate Medical Education, commissioned by the American Medical Association to describe a physician with specific training and expertise; and

WHEREAS, The commission defined the term as a physician educated to provide comprehensive and continuing care including not only the diagnosis and treatment of illness but also its prevention and supportive and rehabilitative care; and

WHEREAS, The citizen's commission recognized that a primary physician should be a function specialist rather than a subject matter or technique specialist and that his graduate training should integrate the disciplines of medicine, psychiatry, pediatrics, medical gynecology, and preventive medicine, as well as provide an understanding of people in their environment; and

WHEREAS, Family Practice, in its full and proper definition, is the only discipline of medicine which meets the criteria set forth by the citizen's commission for a primary physician; and

WHEREAS, The acceptance of the primary physician concept among patients, third-party payers, and various other agencies and organizations has caused other specialty disciplines of medicine to choose to call themselves "Primary Care"; and

WHEREAS, This has resulted in misuse and abuse of the term *Primary Care Physician*, leading to public confusion regarding its true meaning; and

WHEREAS, The definition of a Primary Physician is vitally important to patients, third-party payers, and others in choosing the type of physician they desire; now therefore be it

*Resolved*, That the Oklahoma State Medical Association recognizes the members of the American Academy of Family Physicians as the true and sole primary physician as defined by the American Medical Association Citizen's Commission on Graduate Medical Education, and will work with the American Medical Association to make such a stand as harmonious as possible.

## RESOLUTION 6

(Not Adopted)

Introduced by: Arnold G. Nelson, MD, and Kenneth W. Whittington, MD  
Subject: **Foreign Medical Graduates in Residency Programs**  
Referred to: Reference Committee II

WHEREAS, Residency programs in all disciplines of medicine are experiencing growing problems in the areas of economics and patient availability; and

WHEREAS, Various residency programs are accepting foreign medical graduates; and

WHEREAS, The taxpayers of the United States and of Oklahoma are subsidizing the expense of their training; and

WHEREAS, There is in these United States a surplus of physicians in certain specialties and geographic areas; now therefore be it

*Resolved*, That the Oklahoma State Medical Association and the American Medical Association address this problem in the most practical and compassionate manner possible with continued acceptance of foreign medical graduates whose training is subsidized by their respective countries in anticipation of their return to those countries upon completion of their residency training.

## SUBSTITUTE RESOLUTION 6

(Adopted)

*Resolved*, That the Oklahoma State Medical Association and the American Medical Association urge residency programs in Oklahoma to employ only graduates of LCME-approved medical schools or graduates of foreign medical schools whose training is subsidized by their respective countries and who are required to return to those countries upon completion of their residency training; and be it further

*Resolved*, That the United States Congress be urged to repeal the Desirable Alien Act; and be it further

*Resolved*, That the Oklahoma State Board of Medical Examiners be apprised of this resolution.



Frank A. Clingan, MD, Tulsa, chairman of this year's Scientific Program, introduces his first speaker.



A forceful Glenn L. Haswell, MD, adjunct associate professor of obstetrics and gynecology at OUTMC, appears engrossed in his topic, "Update in Obstetrical Ultrasound."

## RESOLUTION 7

(Not Adopted)

Introduced by: Arnold G. Nelson, MD, and Kenneth W. Whittington, MD

Subject: **Family Physicians' Second Opinions**

Referred to: Reference Committee II

WHEREAS, Family Physicians are qualified by both training and experience to diagnose disease and recommend therapeutic alternatives, both invasive and non-invasive; and

WHEREAS, The scope of such training is broad and not limited by age, sex, or organ system; and

WHEREAS, Family Physicians are unsurpassed in their record of continuing education and voluntary recertification and therefore remain aware of current preferred methods of disease management; and

WHEREAS, As the patient's primary physician, it is the function of the Family Physician to act as the patient's advocate in coordinating the various diagnostic and therapeutic modalities needed in the course of the patient's care; now therefore be it

*Resolved*, That the Oklahoma State Medical Association encourage third-party payers and other interested parties to recognize the ability of Family Physicians to render second opinions regarding the necessity of diagnostic or therapeutic procedures.

## SUBSTITUTE RESOLUTION 7

(Adopted)

*Resolved*, That the OSMA encourage third-party payors and other interested parties to recognize the ability of Primary Care Physicians to render second opinions regarding the necessity of primary care diagnostic or therapeutic procedures.

## RESOLUTION 8

(Not Adopted)

Introduced by: Arnold G. Nelson, MD, and Kenneth W. Whittington, MD

Subject: **Opposition to Dual Fees**

Referred to: Reference Committee III

WHEREAS, It is the clear position of state and federal regulatory agencies, the American Medical Association, and the Joint Commission on Accreditation of Hospitals that practitioners be granted privileges for the practice of medicine solely on the basis of their training and/or expertise; and

WHEREAS, The quality of any procedure is dependent solely upon the skill of the practitioner and not upon the nature of his specialty; now therefore be it

*Resolved*, That the Oklahoma State Medical Association inform third-party payers that reimbursement for diagnostic or therapeutic modalities should be based upon the nature of the service rendered, independent of the practitioner's specialty or organizational affiliation.

## RESOLUTION 9

(Adopted)

Introduced by: Ed L. Calhoun, MD

Subject: **Non-Smokers' Inhalation**

Referred to: Reference Committee II

WHEREAS, Smoking is beyond the shadow of a doubt a chief offender in many of our major diseases of the lung, the heart, and various forms of cancer; and

WHEREAS, Passive smoking (non-smoker inhalation) is responsible for lung disease and various malignancies such as cancer of the lung, pancreas, etc.; and

WHEREAS, Smokers' children have a much higher incidence of chronic colds and lung disorders; and

WHEREAS, Many non-smokers are allergic to tobacco smoke with resulting upper respiratory infections; and

WHEREAS, Common courtesy would decree that non-smokers should not be subjected to passive smoking in public situations; now therefore be it

*Resolved*, That the Oklahoma State Medical Association go on record in favor of the above and transmits to the American Medical Association this resolution.

Norman L. Dunitz, MD, OSMA president 1986-87, watches thoughtfully as the discussion intensifies in a hastily called meeting of "Return to Reason" coalition members, proponents of tort reform in Oklahoma.

## RESOLUTION 10

(Not Adopted)

Introduced by: Robert C. Bowman, MD  
Subject: **Primary Care Physicians**  
Referred to: Reference Committee II

WHEREAS, Oklahoma still has a great need for rural primary care physicians; and

WHEREAS, The present system of medical education encourages the production of non-rural physicians; and

WHEREAS, The medical leadership has a responsibility to the state to provide physicians that fit the needs of the state; and

WHEREAS, The current economic climate will worsen Oklahoma's retention of physicians; and

WHEREAS, The current system of education of physicians is creating and will create problems for all medical education as the people of the state and their elected representatives begin to ask accountance for all those medical education dollars that have gone to educate doctors who subsequently leave the state; now therefore be it

*Resolved*, That the Oklahoma State Medical Association support changes in the medical education system that will create doctors that will be able to locate in areas of Oklahoma that need physicians including but not limited to:

1. A primary care-oriented curriculum from the first day of medical school;
2. More medical education programs (student and resident clerkships) in the less populated areas of the state;
3. Consideration of the resident spending at least part of the third year of residency in a location suitable for his or her eventual practice location.

## SUBSTITUTE RESOLUTION 10

(Adopted)

*Resolved*, That the Oklahoma State Medical Association support changes in the medical education system that will create doctors that will be able to locate in areas of Oklahoma that need physicians including but not limited to:

1. A Primary-care oriented curriculum from the first day of medical school;
2. More medical education programs (student and resident clerkships) in the less populated areas of the state;
3. Consideration of the resident spending at least part of the third year of residency in a location suitable for his or her eventual practice location;
4. Encourage locum tenens in rural Oklahoma practices.



## RESOLUTION 11

(Adopted As Amended)

Introduced by: Robert C. Bowman, MD  
Subject: **Mandatory Assignment**  
Referred to: Reference Committee III

WHEREAS, The Medicare fee scale has fallen years out of date and does not compensate physicians equitably; and

WHEREAS, Certain populations of Medicare patients face ever-increasing out-of-pocket expenses due to these archaic fee scales; and

WHEREAS, Mandatory assignment is nothing but a nationalized health service plan; and

WHEREAS, Medicare patients are beginning to believe that assignment means "free" — undermining the responsibility of the individual for his or her own finances and medical care; and

WHEREAS, Policies of assignment severely punish those younger who are forced to pay the increasing costs of health care; now therefore be it

*Resolved*, That the Oklahoma State Medical Association take whatever means necessary to prevent mandatory assignment including but not limited to: which might include the following:

1. Discussions with seniors groups about the real problem of low and outdated Medicare fee scales and policies;
2. Utilization of the individual member's practice base as a force for prevention of this problem through informational brochures and mailings;
3. Continued discussions with legislative bodies;
4. Court battles;
5. Mobilization of those less than 65 who will have to pay the increased costs of care.

**RESOLUTION 12**

(Not Adopted)

Introduced by: Robert C. Bowman, MD  
 Subject: **Cutbacks in Funding in Prenatal Care**  
 Referred to: Reference Committee II

WHEREAS, Prenatal care is critical to preventing complications of pregnancy; and

WHEREAS, Oklahoma is already deficient in prenatal care; and

WHEREAS, Cutbacks in funding for prenatal care in the Title XIX and State Health Department Funds would contribute to increased infant deaths and complications in the state; now therefore be it

*Resolved*, That the Oklahoma State Medical Association do all that it can to help its members contact legislators and the state departments about the harmful effects of cuts in the prenatal care programs of the state.

**RESOLUTION 13**

(Not Adopted)

Introduced by: Jay A. Gregory, MD  
 Subject: **Mandatory Outpatient Tonsillectomies and Adenoidectomies**  
 Referred to: Reference Committee I

WHEREAS, The Oklahoma State Employees Group Health Plan, Blue Cross/Blue Shield and other third-party payors have made it mandatory for tonsillectomies and adenoidectomies to be done as an outpatient procedure; and

WHEREAS, The American Academy of Otolaryngology adopted the position that outpatient tonsillectomies and adenoidectomies should be avoided except under very limited circumstances; and

WHEREAS, In February of 1984 the Oklahoma Academy of Otolaryngology adopted the following position that, "It is now the official position of the Academy that tonsillectomies and adenoidectomies should be considered an inpatient procedure most of the time, but under certain circumstances, to be decided only by the physician, this procedure may be done on an outpatient basis. This decision is a medical decision that can be made only by the physician involved and cannot safely be made by either patient or a third-party payor;" and

WHEREAS, Several physicians throughout the state have agreed with Blue Cross/Blue Shield and/or Oklahoma State Employees Group Health Plan or other third-party payors to perform tonsillectomies and adenoidectomies routinely on outpatient basing their decision solely on economics; and

WHEREAS, The potential liability for any catastrophic complication which should arise, would be crippling to the Physicians Liability Insurance Company of Oklahoma; now therefore be it

*Resolved*, That the Oklahoma State Medical Association recommend to PLICO that any physician who is routinely performing tonsillectomies and adenoidectomies in the outpatient setting should have all liability insurance removed for those procedures.

(Facing) C. T. Thompson, MD, panel moderator for the Trauma Services program Thursday afternoon, delivers his report, "The Newer Aspects of Trauma." Dr Thompson is a clinical professor of surgery at Tulsa Medical College.

**RESOLUTION 14**

(Not Adopted)

Introduced by: Jay A. Gregory, MD  
 Subject: **Mandatory Outpatient Surgery for Hernia Repairs**  
 Referred to: Reference Committee I

WHEREAS, Blue Cross/Blue Shield and its March 1986 directory recommended that repair of unilateral, inguinal hernias both direct and indirect and unilateral femoral hernias and umbilical hernias be performed as outpatient procedures; and

WHEREAS, Such decisions are being made on solely economic issues to make it mandatory for these procedures being done as an outpatient procedure; and

WHEREAS, Physicians who are accepting contracts or agreements to perform said procedures solely as an outpatient procedure based solely on economic issues, are placing the Physicians Liability Insurance Company of Oklahoma in jeopardy; now therefore be it

*Resolved*, That the Oklahoma State Medical Association recommend the withdrawal of PLICO's liability coverage to those physicians who routinely perform these procedures in the outpatient setting, when the decision to do so is based solely on economic issues.

**RESOLUTION 15**

(Adopted As Amended)

Introduced by: Leon Horowitz, MD  
 Subject: **Ending Tobacco Supports**  
 Referred to: Reference Committee I

WHEREAS, The American Medical Association House of Delegates meeting in June, 1985, approved Resolution 77 (A-85) entitled "Ending Tobacco Subsidies" which: "RESOLVED, That the American Medical Association oppose federal support to the tobacco industry and urge Congress to end such support"; and

WHEREAS, At a hearing to discuss restructuring the troubled tobacco price support system, the Coalition for Smoking OR Health which is composed of the American Cancer Society, the American Lung Association and the American Heart Association stated that it found nothing objectionable about funding a tobacco price support system; and



WHEREAS, Congress has not responded to the request of the American Medical Association; and

WHEREAS, It would buttress the position of the American Medical Association if many other national organizations passed a similar resolution and made their resolution known to Congress; now therefore be it

~~Resolved, That the American Medical Association House of Delegates direct the Board of Trustees of the American Medical Association to inform all appropriate national medically-oriented organizations of this resolution and urge and challenge them to take similar action.~~

Resolved, That the Oklahoma Delegates to the AMA House of Delegates introduce a resolution in that body asking the AMA Board of Trustees to inform all appropriate national medical-oriented organizations of the importance of Resolution 77 (A-85) which expresses the AMA's opposition to the tobacco industry and, further, urge and challenge other organizations to take similar action.

## RESOLUTION 16

(Not Adopted)

Introduced by: Eugene G. Feild, MD  
Subject: **Formation of a Non-Profit HMO by OSMA**  
Referred to: Reference Committee III

WHEREAS, The physician has been the protector and guardian of quality health care over thousands of years on this earth; and

WHEREAS, Multi-billion dollar international corporations have entered the health care market in Oklahoma; and

WHEREAS, These corporations have their primary goal as being profit structure for that corporation, be it international or statewide, exacting its profits through discounts and treatment-deferring restrictions; and

WHEREAS, In spite of the multiple IPAs that are being formed and have been formed in Oklahoma, no company is willing to deal with quality care issues on an inpatient/outpatient basis, nor is any company interested at this time in any form of peer review done by the physicians; now therefore be it

*Resolved*, That the Oklahoma State Medical Association take prudent and rapid steps toward formation of a non-profit HMO owned and organized by the OSMA. Such an organization would have its primary goal as delivery of the highest quality care to patients in a non-profit alternative care delivery mode.

## RESOLUTION 17

(Adopted)

Introduced by: Orange M. Welborn, MD  
Subject: **Smokeless Tobacco Education and Prohibiting Use of All Tobacco Products in Schools**  
Referred to: Reference Committee II

WHEREAS, The use of smokeless tobacco products has been demonstrated to cause oral cancer, oral leukoplakia, and gingival diseases; and

WHEREAS, Evidence indicates that smokeless tobacco products have an addictive potential; and

WHEREAS, There has been an alarming increase in the use of smokeless tobacco products among children in elementary and secondary schools; and

WHEREAS, The American public and especially children have not been adequately alerted to the health risks of the use of smokeless tobacco; now therefore be it

*Resolved*, That the Oklahoma State Medical Association encourage incorporation of smokeless tobacco education into school education programs; and be it further

*Resolved*, That the OSMA encourage the appropriate school authorities to prohibit the use of all tobacco products by students, faculty, and coaches during the school day, and during other school-related activities; and be it further

*Resolved*, That the OSMA encourage the incorporation of appropriate intervention programs with existing programs as they are developed; and be it further

*Resolved*, That copies of this Resolution be forwarded to the U.S. Department of Education, the Oklahoma State Department of Education, and that this subject be introduced to the House of Delegates of the American Medical Association.

## RESOLUTION 18

(Adopted As Amended)

Introduced by: Oklahoma County Medical Society  
Subject: **Limiting Terms of AMA Delegates**  
Referred to: Reference Committee I

WHEREAS, Physicians willing to get involved are the most essential ingredients in a viable medical society; and

WHEREAS, There has been much discussion about how to get more physicians involved in the operations and politics of organized medicine; and

WHEREAS, Many interested physicians are not willing to oppose someone who has been in a position for a long period of time; and

WHEREAS, Restricting the length of time a person can hold a position will increase participation and present new ideas and viewpoints; now therefore be it

*Resolved*, That the Oklahoma State Medical Association Delegation to the American Medical Association introduce and support a change in the AMA Bylaws to limit the number of years an individual can serve as a Delegate to the AMA to six (6) consecutive two-year terms.

## RESOLUTION 19

(Adopted)

Introduced by: Council on Public and Mental Health  
Subject: **Governor's Task Force on Perinatal Care**  
Referred to: Reference Committee II

WHEREAS, A goal of universal access to maternity and infant care needs to be established in Oklahoma; and

WHEREAS, There is a need for increased public awareness for and availability of prenatal care; and

WHEREAS, There is a need to develop a timely and comprehensive method of collecting data in order to properly plan for future perinatal health care needs; and

WHEREAS, There is a need to increase the availability of maternal and infant care providers; and

WHEREAS, There needs to be designed a state transportation system to assure a smoothly working regionalized perinatal care system; and

WHEREAS, There is a need to expand availability of special adolescent health clinics; and

WHEREAS, There is a need to emphasize the importance of preconception care since health pregnancies begin before conception; and

WHEREAS, There is a need to improve the quality of prenatal care by updating the content of care to encompass new developments and knowledge in maternity services; and

WHEREAS, There is a need to support a perinatal education program for health care providers; and

WHEREAS, There is a need to assure adequate reimbursement so that hospital and physician are not discouraged from providing prenatal care to the poor or "medically needy"; and

WHEREAS, There is a need to organize a statewide high-risk infant follow-up project designed to improve perinatal health and education; and

WHEREAS, There is a need to establish systems to recruit hard-to-reach women into care; now therefore be it

*Resolved*, That the Oklahoma State Medical Association House of Delegates endorse and support the report of the Governor's Task Force on Perinatal Care; and be it further

*Resolved*, That the Perinatal Task Force of OSMA be designated the responsibility of working toward the support and attainment of the goals and objectives of the report of the Governor's Task Force on Perinatal Care.



Expressions vary on the floor of the House of Delegates during Thursday morning's Opening Session.

## RESOLUTION 20

(Adopted)

Introduced by: Council on Planning and Development  
Subject: **OSMA Annual Meeting**  
Referred to: Reference Committee III

WHEREAS, There has been a continuous and steady decline in attendance at the Annual OSMA Meeting, especially noticeable in the Scientific Programs; and

WHEREAS, There has been a steady increase in the cost of the meeting to the Association that could not be offset by the sale of exhibit booths or increased prices for meal function tickets; and

WHEREAS, Many other state associations have experienced a similar decline in attendance and have chosen to drop the Scientific portion of the program and all exhibits in order to more appropriately utilize funds for the benefit of the maximum number of members; and

WHEREAS, Physicians are now faced with a plethora of scientific medical continuing medical education programs being offered by hospitals, universities, medical schools, and state and national medical specialty societies; now therefore be it

*Resolved*, That this House of Delegates authorize the President of the OSMA to discontinue the sale of exhibit space and the medical scientific programs conducted in conjunction with the Annual Meeting of the Association, except that at least a portion of the Annual Meeting could be devoted to a socioeconomic program of interest to as many Association members as possible.

## RESOLUTION 21

(Adopted As Amended)

Introduced by: Council on Planning and Development  
Subject: **Committee on Medical Ethics and Competency**  
Referred to: Reference Committee I

WHEREAS, Under the present committee and council structure of the OSMA there is no body designated to make recommendations to the Association's Board of Trustees on general ethical questions, except where there is a specific grievance; and

WHEREAS, There is no body designated to evaluate the general medical, physical, or mental competency of an OSMA member when such is brought into question; and

WHEREAS, Both of these areas are of specific concern to physicians as a profession, to individual physicians, to the Oklahoma State Medical Association, and to the Board of Medical Examiners; and

WHEREAS, The most appropriate body in the OSMA structure to hear such questions is the Grievance Committee, consisting of the last five living Past Presidents (excluding the Immediate Past President) who are residing in the state of Oklahoma, the Chairman of the Council on Member Services, the Chairman of the Council on Medical Services, and two members appointed by the President each year. However, in order to do so, it will be necessary for the duties of the Grievance Committee to be expanded; now therefore be it

*Resolved*, That the House of Delegates hereby amend the Bylaws of the Oklahoma State Medical Association to provide for the creation of a Committee on Medical Ethics and Competency to replace the current Grievance Committee. To accomplish this the following bylaw amendments are proposed:

Wherever the term "Grievance Committee" appears throughout the bylaws, the term should be replaced by "Committee on Medical Ethics and Competency."

Chapter X, Section 4.02, is amended as follows:

**PURPOSE.** It shall be the purpose of the ~~Grievance Committee~~ Committee on Medical Ethics and Competency to investigate general ethical conditions and questions of medical ethics whether same is presented as a general question or a specific grievance or complaint, and to make recommendations to the Board of Trustees and the House of Delegates in regard to the establishment of principles and interpretations of medical ethics. ~~Further, the Committee shall investigate complaints or allegations of the possible loss of an OSMA member's professional competency, mental competency, or physical competency as the latter shall affect the practice of medicine.~~ Further, the Committee shall investigate complaints or allegations of the possible loss or absence of an OSMA member's medical, clinical, scientific or mental competency, or physical competency, as the latter shall affect the practice of medicine. In addition, the Committee shall investigate, as a part of competency, the individual physician's understanding of the medical practice laws. ~~It shall be the purpose of the Grievance Committee to~~ Where a formal complaint is received, the Committee shall seek to mediate complaints to the mutual satisfaction of the complainant and the accused physician, and to thereby enhance public or interprofessional relations.

Section 4.06 is amended as follows:

**DISPOSITION OF CASES. COMPLAINTS OR ALLEGATIONS.** After the investigation and deliberation of a complaint, the Committee shall have a choice of one of the following dispositions:

(a) To dismiss the case complaint or allegation because of insufficient grounds, and to so advise the complainant and the accused physician;

(b) To attempt to mediate the complaint to the satisfaction and understanding of all parties concerned;

(c) To recommend corrective actions on the part of the accused physician, requiring satisfactory evidence of compliance within a reasonable length of time; or,

(d) In the absence of other satisfactory alternatives, to refer the case to the Board of Trustees, together with a complete record and recommendation for appropriate disciplinary measures.; or,

~~(e) In cases of impaired competency, to report same promptly to the Board of Medical Examiners for investigation and appropriate action and to the Physician Recovery Committee, if appropriate.~~

(e) In cases of impaired competency or for statutory reasons, to report same promptly to the Board of Medical Examiners for investigation and appropriate action, and/or to the Physician Recovery Committee if appropriate.

**RESOLUTION 22**

(Adopted)

Introduced by: Council on Public and Mental Health  
 Subject: **Medical Health Officers**  
 Referred to: Reference Committee II

WHEREAS, Both the Tulsa City-County and Oklahoma City-County Health Departments are currently headed by nonmedical acting directors; and

WHEREAS, There has been a tendency throughout the country to replace medical health officers by nonmedical administrators at both the state and local levels, and

WHEREAS, It is the belief and policy of the Oklahoma State Medical Association that the assurance of appropriate and truly health-relevant public health services is best maintained by having health departments headed by medical health officers, i.e., physicians trained and experienced in public health; now therefore be it

*Resolved*, That the Oklahoma State Medical Association recommend to the Governor of the State of Oklahoma, the Legislature, the State Board of Health, and the Board of Health of the Tulsa and Oklahoma City-County Health Departments that the Oklahoma State Department of Health and the City-County Health Departments in Tulsa and Oklahoma City (and other local health departments of the state as feasible) continue to be headed by medical health officers.

**RESOLUTION 23**

(Adopted)

Introduced by: Council on Public and Mental Health  
 Subject: **Crisis Intervention Center**  
 Referred to: Reference Committee II

WHEREAS, Because of the fiscal problems of the State of Oklahoma related to depression of the oil industry, there is a tendency to reduce public health and mental health services in the state of Oklahoma; and

WHEREAS, The crisis intervention services of the Tulsa Mental Health Council, Incorporated, have provided an indispensable resource to mental health counseling and civil court commitment services in Tulsa County; and

WHEREAS, There is a vital need to increase rather than reduce outpatient crisis intervention types of mental health services; now therefore be it

*Resolved*, That the Oklahoma State Medical Association recommend to the Legislature and the Commissioner of Mental Health of the State of Oklahoma requesting that, if at all possible, funding be continued for the Crisis Intervention Center of the Tulsa Mental Health Council, Incorporated, and other similar programs in the state to provide crisis intervention on an outpatient basis.

(Late Resolution)

**RESOLUTION 24**

(Not Adopted)

Introduced by: Edward J. Tomsovic, MD  
 Subject: **Revocation of Resident Assessment**  
 Referred to: Reference Committee I

WHEREAS, The Oklahoma State Medical Association has assessed physicians in residency training in the State of Oklahoma an amount of \$300.00; and

WHEREAS, This assessment will be burdensome to residents who have limited income and who are often carrying heavy debts incurred in funding their medical education as well as supporting young families; and

WHEREAS, This assessment may have the unfortunate effect of turning young physicians against organized medicine with consequent loss of their support for future years; now therefore be it

*Resolved*, That the Oklahoma State Medical Association hereby revoke the assessment against resident physicians.

(Facing) The delegates in Reference Committee I begin their afternoon's work. On the far left is Rick Ernest, executive director of the Oklahoma County Medical Society. Front and center is Rod Frates, president of C. L. Frates & Company, administrator of OSMA's PLICO insurance plans.

## Reference Committee I

# REPORTS TO THE HOUSE OF DELEGATES

### Report of REFERENCE COMMITTEE I

Presented by: Mary Anne McCaffree, MD, Chairperson

Mr Speaker and Members of the House of Delegates:

Reference Committee I gave careful consideration to several items referred to it and submits the following report:

(1) *Report of the Board of Trustees*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Board of Trustees be filed for information.

(2) *Supplemental Report of the Board of Trustees*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Supplemental Report of the Board of Trustees be filed for information.

Mr Speaker, your Reference Committee suggests that the Oklahoma State Medical Association Board of Trustees publicize the names of the nominees for the PLICO Board of Directors in advance of the Annual Meeting of this House of Delegates. However, the Reference Committee does not suggest this be put in a form mandating such action, but does suggest that the Trustees consider this in the future.

(3) *Report of the Secretary-Treasurer*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Secretary-Treasurer be filed for information.

(4) *Report of the Budget and Audit Committee*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Budget and Audit Committee be filed for information.

(5) *Report of the Council on Long-Range Planning and Development*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Long-Range Planning and Development be adopted.

(6) *Report of the Constitution and Bylaws Committee*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Constitution and Bylaws Committee be adopted.

Mr Speaker, the House is reminded that by adopting the Constitution and Bylaws Committee Report, the Constitution of the Oklahoma State Medical Association is amended to provide for the seating of voting delegates to represent the Hospital Medical Staff Section, the Resident Physician Section, and the Medical Student Section.



- (7) *Report of the Physicians Liability Insurance Company Recommendation:*  
Mr Speaker, your Reference Committee recommends that the Report of the Physicians Liability Insurance Company be filed for information.
- (8) *Report of the Return to Reason Coalition Recommendation:*  
Mr Speaker, your Reference Committee recommends that the Report of the Return to Reason Coalition be filed for information.
- (9) *Report of the OSMA Auxiliary Recommendation:*  
Mr Speaker, your Reference Committee recommends that the Report of the OSMA Auxiliary be filed for information.
- (10) *Resolution 2 — Physician-Attorney Involvement*  
Mr Speaker, your Reference Committee recommends that Resolution 2 not be adopted.

The members of the Reference Committee endorse the concerns expressed in this resolution. However, the choice of legal counsel should be made by those who best know the capabilities of the attorneys.

- (11) *Resolution 13 — Mandatory Outpatient T & A Recommendation:*  
Mr Speaker, your Reference Committee recommends that Resolution 13 not be adopted.
- (12) *Resolution 14 — Mandatory Outpatient Surgery for Hernia Repair Recommendation:*  
Mr Speaker, your Reference Committee recommends that Resolution 14 not be adopted.
- (13) *Resolution 15 — Ending Tobacco Supports Recommendation:*  
Mr Speaker, your Reference Committee recommends that Resolution 15 be adopted with the following amendment of the Resolve paragraph beginning on line 19 to read as follows:  
"Resolved, That the Oklahoma Delegates to the AMA House of Delegates introduce a resolution in that body asking the AMA Board of Trustees to inform all appropriate national medical-oriented organizations of the importance of Resolution 77 (A-85) which expresses the AMA's opposition to the tobacco industry and, further, urge and challenge other organizations to take similar action."
- (14) *Resolution 18 — Limiting Terms of AMA Delegates Recommendation:*  
Mr Speaker, your Reference Committee recommends that Resolution 18 be adopted with the following amendment:

On line 16 the word *consecutive* should be inserted after the figure 6 in parentheses and before the phrase *two-year terms*.

This is only a clarification amendment.

- (15) *Resolution 21 — Committee on Medical Ethics and Competency Recommendation:*  
Mr Speaker, your Reference Committee recommends that Resolution 21 be adopted with the following amendment:



Norman L. Dunitz, MD, OSMA president 1986-87, and Elvin M. Amen, MD, OSMA president 1985-86, share the spotlight at the Inaugural Ball Friday night.

On line 17, page 2, the sentence beginning with the word *Further* is amended to read, *Further, the Committee shall investigate complaints or allegations of the possible loss or absence of an OSMA member's medical, clinical, scientific, or mental competency, or physical competency, as the latter shall affect the practice of medicine.*

Subsection (e), line 21, page 3, is amended to read, *In cases of impaired competency or for statutory reasons, to report same promptly to the Board of Medical Examiners for investigation and appropriate action, and/or to the Physician Recovery Committee if appropriate.*

Your Reference Committee feels that these are only minor, but needed, changes to clarify the intent and purpose of this new committee.

- (16) *Resolution 24 — Revocation of Resident Assessment Recommendation:*  
Mr Speaker, your Reference Committee recommends that Resolution 24 not be adopted.

This Reference Committee recognizes the financial responsibilities that accompany residency training. However, the amount in question is only \$300, but may be paid in two yearly installments of only \$150 each.

Mr Speaker, this concludes the Report of Reference Committee I. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report.

Respectfully submitted,  
Mary Anne McCaffree, MD, Oklahoma City  
James D. Brashear, MD, Norman  
Tim S. Caldwell, MD, Tulsa  
Daniel Carmichael, MD, Oklahoma City  
James R. Rhymer, MD, Clinton  
Stephen Tkach, MD, Oklahoma City  
Ed Kelsay, Staff  
Debra Hinson, Staff

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## Report of the BOARD OF TRUSTEES

Subject: **Annual Report**

Presented by: Michael J. Haugh, MD, Chairman

Referred to: Reference Committee I

### Introduction

The Board of Trustees of the OSMA has completed three of its regular quarterly meetings for organizational year 1985-86. The fourth, or Annual Meeting, of the Board is being held in conjunction with the 1986 Annual Meeting of the Association in Tulsa, Oklahoma. The proceedings of the annual Board meeting will be contained in the supplemental report of the Board of Trustees.

During the past year, the Board met in regular sessions on August 25 and November 17, 1985, and February 8, 1986. A quorum was certified for each meeting with an average of 8 officers, 14 trustees or alternate trustees, and 10 AMA delegates and/or alternate delegates present.

### Council and Committee Reports

Customarily, the Board of Trustees hears reports from all of the OSMA Councils and Committees during each meeting. During 1985-86, most of the Association business that came before the Board of Trustees came through one of these groups. Since these groups also report directly to the House of Delegates on the year's activities, their reports to the Board will not be reproduced here.

From the length and breadth of each report, however, it may be seen that the Board of Trustees spent a great deal of time working with and supervising the council and committee activities to give the Association one of its most active years.

One council activity, however, does deserve separate attention. At the direction of the OSMA House of Delegates and Board of Trustees, the Council on Member Services established a separate for-profit corporation to be known as the "OSMA Member Services Corporation" for the purpose of handling any profit-making activities of the Association and to offer group-purchase benefits to OSMA members.

During its November 17, 1985, meeting, the Board of Trustees appointed the OSMA's Executive Committee as the interim Board of Directors for the for-profit corporation. The organization was separately incorporated on February 13, 1986, and is now operational.

### PLICO Report

Although PLICO will report directly to the House of Delegates, one action taken during the August 25, 1985, meeting of the OSMA Board of Trustees needs to be considered separately.

During that meeting, the OSMA Board of Trustees considered a special recommendation from the PLICO Board of Directors, to wit:

"... The OSMA Board of Trustees and House of Delegates rescind the 1983 action of restricting the number of 3-year terms which members of the insurance company's Board of Directors may serve; the foreshortened tenures in office, as applied to PLICO, are inconsistent with desirable business management standards."

It was the feeling of the PLICO Board of Directors and the OSMA Board of Trustees that the limiting of PLICO Board members to serving only two consecutive terms of three years each was not in the best interest of the company or the Association. Therefore, the Board of Trustees adopted a motion recommending to the House of Delegates that the restriction on the number of consecutive terms for PLICO Board membership be removed.

### Recommendation

It is the recommendation of the OSMA Board of Trustees that the House of Delegates rescind the 1983 action of restricting the number of 3-year terms which members of the PLICO Board of Directors may serve.

### Ad Hoc Committee on Tenure of OSMA Officers

A special committee on tenure of OSMA officers was created during fiscal year 1984-85 to make recommendations regarding limitations of service. During the August meeting, the Board heard a special report from the committee that made the following recommendations:

a) That the terms of AMA delegates and alternates not be limited at this time, but that they not be allowed to hold other OSMA offices, with the exception of President and President-Elect;

b) That the terms of the Secretary-Treasurer be limited to two 2-year terms and that the office of Assistant Secretary-Treasurer be established, to be filled the last two years of the Secretary-Treasurer's 4-year tenure;

c) That the terms of the Speaker of the OSMA House of Delegates should be limited to two 2-year staggered terms; and

d) That the Chairman of the Board of Trustees be limited to one 3-year term.

After deliberation and discussion, it was determined that this special report should go first to the OSMA's Council on Planning and Development for consideration.

During the November 17 Trustees meeting, it was reported that the Planning and Development Council had considered the report and recommended that the Board of Trustees adopt only the last paragraph which recommended the following:

"As a means to encourage greater participation in the OSMA by more physicians, the committee recommends that (1) a workshop or leadership class be held at least once a year to better educate those physicians wishing to become more active in the leadership of the OSMA; (2) each county continue to actively encourage greater participation in the OSMA election process. The latter recommendation cannot be over-emphasized, as it is the committee's hope that there will be at least two candidates for each office."

This section was adopted by the Board of Trustees along with a statement as follows:

"It is recommended that the Board of Trustees encourage at least two nominees for general officers and AMA delegate and alternate delegate positions."

In response to the recommendation that a leadership conference be held, the OSMA sponsored such a conference on Saturday, April 19, with an attendance of over 150 physicians.

### Special House of Delegates Session

A special session of the OSMA House of Delegates was authorized by the Board of Trustees during its November 17 meeting. At that time, three separate reasons for calling such a special session were discussed:

First, there was a possibility that the loss of professional liability insurance by the Osteopathic profession in the state of Oklahoma could result in the state insurance commissioner creating a joint underwriting association and require PLICO to take part of the liability;

Second, there was need for a general membership meeting of the House to discuss funding for the Return to Reason Coalition and its efforts to seek tort reform at the State Legislature in 1986; and,

Third, PLICO needed to build up its surplus funds so it would be in a better position to negotiate for a continuation of occurrence-type professional liability coverage when seeking re-insurance in the international marketplace.

The special meeting of the House of Delegates was held on February 9.

### Special Candidates Fund

At the recommendation of the Planning and Development Council, the OSMA Board of Trustees created a special fund of \$5,000 minimum per year to assist Oklahoma physicians interested in running for council, Board of Trustees, or general office positions in the American Medical Association. While the Board recognized that such campaigns cost considerably more than the amount set aside, it was felt that the funds could be built up over a period of two or three years and, if necessary, supplemented when needed.

### Regents Commended

A special resolution was adopted by the Trustees as follows: "The OSMA Board of Trustees commend the Regents for Higher Education and encourage them to maintain or even raise the standards of admission to medical school entrants."

### 1987 Annual Meeting

The Board determined that the 1987 Annual Meeting should be held at Shangri-La on Grand Lake.

### Life Membership Awards

The following physicians have been awarded life membership in the Oklahoma State Medical Association through application from component societies, and with the approval of the Association's Board of Trustees:

*August 25, 1985*

Elvin Buford, MD, Guymon  
Robert T. Cronk, MD, Tulsa  
Harold W. Frieze, MD, Broken Arrow  
Robert L. Imler, MD, Tulsa  
Dean Walker, MD, Tulsa

*November 17, 1985*

George M. Brown, MD, McAlester  
James H. Bushart, MD, Lawton  
Denny H. Cramblet, MD, Holdenville  
Edward M. Farris, MD, Oklahoma City  
Maurice C. Gephardt, MD, Muskogee  
Joseph H. Goldberger, MD, El Reno  
Holice E. Hampton, MD, Oklahoma City  
W. Dean Hidy, MD, Tulsa  
Melvin V. Holman, MD, Norman  
H. Kenneth Ihrig, MD, Tulsa  
David B. Lhevine, MD, Tulsa  
Clyde A. Lynn, MD, Norman  
George W. Prothro, MD, Tulsa  
Takeo Takano, MD, Tulsa

*February 8, 1986*

Safety R. First, MD, Tulsa  
John W. Gaddis, MD, Tulsa  
Robert D. Gilmore, MD, Tulsa  
Hall Ketchum, MD, Tulsa  
Jack W. Newport, MD, Tulsa  
Robert D. Shuttee, MD, Enid  
Frank A. Wappler, MD, Tulsa

Respectfully submitted,  
Michael J. Haugh, MD  
Chairman  
OSMA Board of Trustees

## Supplemental Report of the BOARD OF TRUSTEES

Subject: **Supplemental Report**

Presented by: Michael J. Haugh, MD, Chairman

Referred to: Reference Committee I

Mr Speaker and Members of the House:

The Board of Trustees met at its Annual Meeting on Wednesday, May 7, and this supplemental report reviews the actions taken by the board of this meeting. This report will be referred to Reference Committee I to be considered along with the Annual Report of the Board of Trustees, which was included in the Delegate's Handbook. The board meeting was called to order by Michael J. Haugh, MD, Chairman, at 1:50 PM with an invocation by John A. McIntyre, MD, and introductions of guests.

The board approved the minutes of its February 8 meeting as written.



**John C. Sacra, MD, pauses during his talk, "Initial Resuscitation," part of the Trauma Services section of this year's Scientific Program. Dr Sacra, medical director of emergency services at Tulsa's Saint Francis Hospital, also spoke on "How and When to Transport."**

Mrs Mary Ann Deen, outgoing Auxiliary President, began her report by quizzing the board members on facts about the auxiliary. She then reported on the numerous auxiliary projects and activities for the past year. She commended the auxiliaries for their dedication and hard work, and congratulated the board for its support of the auxiliary.

Dr Edward J. Tomsovic, General Chairman of the Annual Meeting, reviewed the various functions planned for this year's meeting. He noted that Dr Frank A. Clingan, Chairman of the Scientific Program, has planned various interesting topics with excellent speakers. He also noted that exhibit booths are completely sold out this year and that various drawings have been planned during the days that exhibits are set up to enhance traffic in the exhibit area. Doctor Tomsovic added that exhibits will be a strength at this meeting. He then announced that Mr Richard Crawford, newly elected Mayor of Tulsa, will address the House of Delegates at its Opening Session.

Elvin M. Amen, MD, President, gave his final report to the board. He commented on the involvement and participation achieved this year at all levels of association activity. Doctor Amen then reviewed various activities of this past year, including trips to Washington, DC, to meet with the Oklahoma Delegation and work done to accomplish tort reform measures through the Return to Reason coalition and at the State Capitol. Doctor Amen pledged support to Dr Norman L. Dunitz, incoming President.

Dr Raymond L. Cornelison, Jr., Secretary-Treasurer, presented his financial report to the board, and noted that the information is included in the handbooks. He reported that the 1985-86 projected deficit of \$100,000 had been reduced to \$80,000. He also noted that the Hartford Insurance Company owes the OSMA \$370,000 from a professional liability insurance program created several years ago. Doctor Cornelison suggested that if and when OSMA receives the money that it should be used for surplus and interest income purposes.

Doctor Cornelison explained that interest income had declined due to lowered interest rates. He also noted that OSMA had been receiving approximately \$100,000 a year from OFPR through a lease agreement for the use of OSMA's computer; however, the foundation plans to purchase its own computer system, and OSMA in turn may lease computer time from OFPR. He explained that this will mean a decrease in revenue, but noted that the association plans to sell its system for approximately \$50-60,000.

Doctor Cornelison reported that the Executive Committee discussed the need for a dues increase in 1987, but recommends to the board that a committee be formed to consider ways of decreasing expenses and increasing non-dues income. The board recommends to the House of Delegates the formation of this special committee to study OSMA's financial condition in lieu of a dues increase.

Mr Bickham had the 1985 PLICO Annual Report brochures distributed for the board's review. These reports are made available to the House of Delegates as a part of Reference Committee I.

Dr M. Joe Crosthwait, AMA Delegation Chairman, reviewed activities from the AMA Interim Meeting held last December. He discussed the various issues that will be considered at the AMA Annual Meeting this June and welcomed comments and suggestions from the board.

Dr Marcus B. Shook, OFPR Board President-Elect, presented the report of the Foundation for Peer Review. Doctor Shook discussed the OFPR's PRO program, which consists of four areas: 1) gathering of history and physical information as an initial database; 2) expanding the database by looking for new information; 3) treatment and monitoring of treatment; and 4) discharge planning — preparation for life outside the hospital. Doctor Shook then answered questions from the group.

Mr David Bickham then presented his Executive Director's report, which included the following items:

The "Return to Reason" Coalition report was distributed to the board for review, and is made available to the House for consideration under Reference Committee I.

Life membership for Past Presidents of OSMA was discussed and proposed, but was rejected.

The OSMA computer situation was further discussed. The board authorized Mr Bickham to contract with OFPR for computer time on their new system.

Mr Bickham referred the board to Late Resolution #24, which deals with revoking the OSMA assessment for resident physicians. The resolution was approved by the board for consideration by the House of Delegates under Reference Committee I.

Mr Bickham reported that he has received a volume of letters from physicians who, for reasons indicated in their letters, feel they should be exempt from the assessment. Doctor Haugh explained that the Executive Committee recommends to the Board of Trustees to form a committee consisting of the President, Secretary-Treasurer, Chairman of the Board, Speaker of the House, and the Executive Director to resolve these petitions. The board approved the recommendation subject to approval of the House.

Mr Bickham then discussed a request by Dr Gary L. Larson, Oklahoma City, for corresponding membership. Mr Bickham explained that Doctor Larson is leaving the state but plans to retain his Oklahoma license, and is considering returning to practice in Oklahoma. Mr Bickham noted that Oklahoma County Medical Society does not have a corresponding membership category, and thus Doctor Larson is making his request to the board. The board approved the request subject to meeting all the requirements for corresponding membership.



OSMA Executive Director David Bickham stands to make his point during the unscheduled meeting of "Return to Reason" coalition members Thursday afternoon. Otie Ann Carr, OSMA's director of state legislation, listens attentively.

Mr Bickham announced some changes in the House of Delegates material: Resolution #11 should be moved from Reference Committee II to Reference Committee III; Resolution #5 in Reference Committee II has been withdrawn; Dr Larry L. Long noted that Resolutions #4, 6, and 7 in Reference Committee II and #8 in Reference Committee III were originally authorized by the Oklahoma Academy of Family Physicians, but the authors have been changed to Drs Arnold G. Nelson and Kenneth W. Whittington. The board accepted these technical changes and approved Resolutions #4, 6, 7, and 8 as Late Resolutions for consideration by the House.

Dr J. B. Eskridge III, Chairman of the Council on Long-Range Planning and Development, presented several recommendations to the board:

#1) The Executive Committee meetings would be limited to General Officers and the Chairman of the AMA Delegation;

#2) The OSMA film produced by the Council on Professional and Public Relations would be given the widest possible distribution to affiliated societies, and that the board would consider special study of the possibility of future films, with emphasis on budgetary considerations;

#3) The OSMA President's compensation would be left at its current level;

#4) The board would establish a task force or ad hoc committee to study mechanisms that would encourage physicians to join the association and the AMA and to explain to them the dollar value of their dues;

#5) The OSMA would consider the creation or development of a symbol that physicians might use on their letterhead, office, billings, etc., indicating that they are members of the OSMA;

#6) Mr Bickham, OSMA Executive Director, would closely monitor the activities of the Return to Reason Coalition and the progress of the various tort reform bills, and utilize his best judgment in all negotiations regarding legislation;

#7) The board would give serious consideration to the formation of an ad hoc committee to investigate the formation of a statewide HMO/IPA for Oklahoma;

#8) The OSMA staff would be directed by the board to prepare a charter or Articles of Incorporation for consideration by Oklahoma and Illinois to form an organization of unified states.

The board approved all of the above except for the recommendation (#7 above) concerning formation of a statewide HMO/IPA, which the board voted to advance to the House without recommendation.

Dr Larry L. Long, OMPAC Chairman, presented his report, which is included in Reference Committee III.

The board elected for 1986-87 Dr Thomas Lynn, Jr., and Dr Rollie Rhodes, Jr., as Chairman and Vice-Chairman of the board, respectively.

The board then reappointed Dr Harris D. Riley, Jr., as an Editor of the OSMA JOURNAL. The board also appointed as a JOURNAL Editor Dr Donald M. Brawner, Tulsa, to serve the remainder of the term for Dr Robert G. Tompkins, who is resigning from his post.

The board approved the special membership applications submitted for consideration at its annual meeting.

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In other actions, the board instructed the OSMA staff to develop a survey of the number of physicians 70 years old and above who are still in active practice; the board approved nominees for the PLICO Board of Directors:

John R. Alexander, MD, Tulsa, Advisory Member

Ed L. Calhoon, MD, Beaver

Billy R. Goetzinger, MD, Oklahoma City

Floyd F. Miller, MD, Tulsa

Ray V. McIntyre, MD, Kingfisher

The board approved the Constitution and Bylaws of the newly formed OSMA Student Section with an amendment, whereby these bylaws cannot be altered without approval by the Board of Trustees; the board also approved the bylaws of the Section on Hospital Medical Staffs; the board tabled until the next meeting a request for OSMA participation in a lawsuit against lawyers who filed an allegedly frivolous suit against named OSMA members.

There being no further business, the board adjourned at 4:30 PM.

Respectfully submitted,  
Michael J. Haugh, MD  
Chairman of the Board

## **Report of the SECRETARY-TREASURER**

Subject: **Annual Report**

Presented by: Raymond L. Cornelison, Jr., MD  
Secretary-Treasurer

Referred to: Reference Committee I

### **Audit Report**

The association remains in viable financial condition with assets in excess of 5.5 million dollars of which \$1.1 million is in cash and dues receivable. The 1985 budget projected a deficit of \$100,000. The actual shortfall was about \$80,000 which resulted from non-recurring programs and projects. PLICO's operations show a net loss of about \$200,000, thus a net reduction in total assets from \$5.8 million in 1984.

During calendar year 1985 the association put an additional \$500,000 into the capital and surplus of PLICO, raising PLICO's surplus to about \$3.4 million. The additional cash enabled PLICO to raise its primary coverage layer to \$400,000. It is obvious that the association cannot continue to take from its surplus to infuse new capital in PLICO.

Liabilities have not changed significantly from 1984, but two earmarked funds have been eliminated. The public education fund and the building maintenance fund were transferred to the general operations fund. The public education fund was used to defray special public relations projects, and the building maintenance fund was likewise eliminated since such expenses are paid from general expense accounts.

The association has accounts receivable from the FDIC as a result of Penn Square Bank closing and from the Hartford Insurance Company. OSMA's surplus deposits in Penn Square totaled \$423,000, of which \$226,928 has been collected. While no receivable is shown on the books since one-half of the debt was written off, there is still a strong possibility that OSMA will continue to receive annual payments. The \$370,000 due from Hartford is the result of a reinsurance agreement made in 1976. We proposed to Hartford that the account be closed and the money refunded since there are no outstanding claims. However, Hartford contends there might be future claims. We will continue to negotiate for this refund.

The schedule of revenues identifies the various sources of association income and is consistent with budgeted figures. It should be especially noted that of the \$1.1 million in expenditures, about 60% is from membership dues.

For the past two years OSMA has leased computer services to the Oklahoma Foundation for Peer Review for a little more than \$100,000 per year. It appears that OFPR will buy their own computer this year, which will mean a loss of revenue for OSMA.

The 1985 expenses of the association are detailed in the Schedule of Expenses and for the most part are within budgeted amounts. Data processing, office supplies and utilities are all up. Salaries and special project increases reflect action of the House of Delegates at the last annual meeting. Council expenses are about as predicted. The increase in state government activities is an accounting change; the cost of our contract lobbyist is included in the council expense. The Professional and Public Relations Council expense is up due to increased activity in our Physicians Recovery Program. The association subsidizes the annual meeting each year by about \$50,000, and it is anticipated the delegates will be asked to consider changes in the annual meeting format to reduce expenses.

### **1986 Budget**

The House of Delegates was provided a copy of the proposed 1986 budget at the special session held February 9. However, a revised budget is included in the Handbook. The year-end audit necessitated slight modification. Projected gross revenues are \$1,326,400, and expenditures are projected at \$1,315,400, which would leave an income over expense of \$11,000.

Note: The audited detail statements of Price Waterhouse are available upon request.

Respectfully submitted,  
Raymond L. Cornelison, Jr., MD  
Secretary-Treasurer

March 10, 1986

To the House of Delegates of the  
Oklahoma State Medical Association

We have examined the balance sheet of Oklahoma State Medical Association ("Association") as of December 31, 1985 and 1984 and the related statements of revenues and expenses, of changes in unappropriated fund balance and of changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the accounting records and such other auditing procedures as we considered necessary in the circumstances. We did not examine the financial statements of Physicians Liability Insurance Company ("Company"), a wholly-owned unconsolidated subsidiary accounted for on the equity method of accounting. The investment in the Company represents 61% and 53% of total assets of the Association for the years ended December 31, 1985 and 1984, respectively; for the years ended December 31, 1985 and 1984, the Association recorded losses of \$196,734 and \$509,055, respectively, on its investment in the Company. The financial statements of the Company were examined by other independent accountants whose report dated February 21, 1986 expressed an unqualified opinion on those statements, and our opinion expressed herein, insofar as it relates to the amounts included for the Company, is based solely upon the report of other accountants.

The Association does not provide for depreciation on buildings estimated at \$15,000 for 1985 and 1984 as required by generally accepted accounting principles.

In our opinion, except for not providing for depreciation as described in the preceding paragraph and based upon the report of other independent accountants referred to above, the financial statements referred to above present fairly the financial position of Oklahoma State Medical Association as of December 31, 1985 and 1984, the results of operations and the changes in its financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Our examinations were made for the purpose of forming an opinion on the basic financial statements taken as a whole. The supplemental schedules are presented for purposes of additional analysis and are not a required part of the basic financial statements. Such information has been subjected to the auditing procedures applied in the examinations of the basic financial statements and, in our opinion, is fairly stated in all material respects in relation to the basic financial statements taken as a whole.

Price Waterhouse

**Oklahoma State Medical Association  
Balance Sheet**

**Assets**

December 31,

1985 1984

**Current assets:**

Cash	\$ 1,559	\$ 9,354
Savings accounts and certificates of deposit	474,692	953,568
Accounts receivable — Dues	644,301	644,733
Inventory	17,233	—
Prepaid expenses	11,090	5,033
Total current assets	1,148,875	1,612,688

**Property and equipment:**

Land	7,808	7,808
Building (Note 4)	383,093	379,515
Pavement	2,451	2,451
Furniture, fixtures and equipment	448,834	419,354
Equipment under capital lease (Note 4)	15,330	15,330
	857,516	824,458
Less — Accumulated depreciation	(228,446)	(161,240)
	629,070	663,218

**Equity in unconsolidated subsidiary  
(Note 10)**

	3,399,435	3,096,169
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**Other assets:**

Due from reinsurance companies (Note 11)	370,000	370,000
Due from Federal Deposit Insurance Corporation, net of allowance of \$211,401 (Note 2)	—	72,196
Loan acquisition costs, net of amortization	3,843	4,282
	373,843	446,478
	\$5,551,223	\$5,818,553

The accompanying notes are an integral part of this statement.

**Liabilities and Fund Balances**

December 31,

1985 1984

**Current liabilities:**

Current portion of long-term debt	\$ 7,075	\$ 6,205
Accounts payable (Note 3)	443,797	439,257
Loans and scholarships payable	—	100
Accrued pension costs (Note 5)	1,900	1,900
Deferred income (Note 6)	656,185	641,550
Total current liabilities	1,108,957	1,089,012

**Long-term debt (Note 4)**

	135,134	142,012
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**Commitments and related party transactions  
(Notes 7 and 8)**

	—	—
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**Fund balances:**

Appropriated for public education	—	35,619
Appropriated for building maintenance	—	30,217
Unappropriated	4,307,132	4,521,693
	4,307,132	4,587,529
	\$5,551,223	\$5,818,553

**Schedule of Revenues**

Years ended December 31,

1985 1984

**From operations:**

Membership dues	\$612,907	\$629,636
Interest and other	102,949	187,652
Building lease	29,400	33,205
Membership directory	5,166	12,348
Computer	136,195	90,434
Total revenue from operations	\$886,617	\$953,275

**From JOURNAL:**

Subscriptions allocated from dues	\$ 31,346	\$ 31,302
Advertising and sales	78,562	56,096
Total revenue from JOURNAL	\$109,908	\$ 87,398

**From annual meeting:**

Exhibit fees	\$ 26,130	\$ 22,235
Contributions	800	450
Ticket sales	14,515	20,071
Short courses	1,035	—
Total revenue from annual meeting	\$ 42,480	\$ 42,756



Robert G. Tompkins, MD, left, longtime member of the JOURNAL's Editorial Board, talks with Dr and Mrs Dunitz during the Inaugural Ball. Dr Tompkins recently resigned from the Editorial Board and Donald L. Brawner, MD, Tulsa, has been appointed to fill his unexpired term.

# Schedule of Expenses

	Years ended December 31,	
	1985	1984
<b>General membership expenses:</b>		
Salaries	\$ 324,503	\$301,921
Awards	2,173	1,606
Councils	108,837	92,383
Data processing	26,864	14,326
Depreciation and amortization	67,644	47,679
Dues and subscriptions	2,917	4,516
Equipment rental and expense	32,350	33,772
In-state travel	1,613	3,118
Insurance	40,916	44,913
Interest	14,536	16,403
Legal and professional	12,032	10,850
Loss prevention project	46,728	36,623
Office supplies	25,502	15,922
OSMA newsletter	8,909	9,868
Out-of-state travel and AMA convention	73,696	91,957
Payroll taxes	23,995	22,761
Pension costs	25,509	26,406
Physicians recovery program	26,066	8,876
Postage and shipping	31,510	30,215
Repairs and maintenance	7,686	10,035
Services	3,621	3,632
Special projects	53,289	—
Staff and officers	47,008	25,269
Telephone and utilities	44,614	40,824
Other general expense	7,884	9,587
Total before allocation of overhead	1,060,402	903,462
Expense reimbursement from subsidiary	(125,000)	(100,000)
Overhead allocated to JOURNAL	(34,974)	(29,530)
Overhead allocated to annual meeting	(33,329)	(31,751)
<b>Total general membership expenses</b>	<b>\$ 867,099</b>	<b>\$742,181</b>
<b>Council expenses:</b>		
State governmental activities	\$ 64,250	\$31,836
Federal governmental activities	27,856	23,008
Medical education	1,081	1,228
Medical services	(7,450)	(1,434)
Member services	(9,110)	8,910
Planning and development	4,366	8,763
Professional and public relations	26,601	19,180
Public and mental health	126	—
Hospital medical staffs	1,117	892
<b>Total council expenses</b>	<b>\$ 108,837</b>	<b>\$ 92,383</b>
<b>JOURNAL expenses:</b>		
Salaries	\$ 36,000	\$ 36,000
Advertising	15,720	13,362
Artwork	5,580	4,792
Printing	63,450	59,437
Proofreading	1,019	895
Supplies and other	6,319	12,314
Total before allocation of overhead	128,088	126,800
Overhead allocated from general membership expenses	34,974	29,530
<b>Total JOURNAL expenses</b>	<b>\$163,062</b>	<b>\$154,330</b>
<b>Annual meeting expenses:</b>		
Exhibit expense	\$ 92	\$ 2,705
Travel	6	619
Special events	3,022	—
Printing	8,209	7,055
Speaker	1,878	5,026
Entertainment	1,250	4,827
Luncheon	1,164	188
Signs and security	1,508	773
Audio visual equipment	3,926	1,023
Sports activities	965	40
Hotel	29,498	31,522
Ladies activities	3,197	—
Other	4,463	3,287
Total before allocation of overhead	59,178	57,065
Overhead allocated from general membership expenses	33,329	31,751
<b>Total annual meeting expenses</b>	<b>\$ 92,507</b>	<b>\$ 88,816</b>



Rosalie Rahe, AMA-ERF chairman for the OSMA Auxiliary, announces this year's donations to Oklahoma's three medical colleges, the University of Oklahoma College of Medicine in Oklahoma City, the University of Oklahoma Tulsa Medical College, and Tulsa's Oral Roberts University.

## Balance Sheet March 31, 1986

<b>Current Assets</b>	
Cash	\$ 29,799
Savings accounts and certificates of deposit	860,400
Accounts receivable	164,939
Accounts receivable - Insurance premium refund	370,000
Prepaid expenses	16,618
<b>Total Current Assets</b>	<b>1,441,756</b>
<b>Property and Equipment</b>	
Land	7,808
Building	384,998
Pavement	2,451
Furniture, fixtures and equipment	174,074
Electronic data processing	274,975
Equipment under capital lease	15,330
	859,636
Less: Accumulated depreciation and amortization	233,381
	626,255
<b>Investment in Subsidiary</b>	<b>3,399,435</b>
<b>Other Assets</b>	
Loan acquisition costs - net of amortization	3,733
<b>Total</b>	<b>\$5,471,179</b>
<b>Current Liabilities</b>	
Current portion of long-term liabilities	\$ 6,205
Accounts payable	490,802
Loan and scholarships payable	7,614
Student fund	608
Retirement expense	1,900
Deferred income - Dues	492,139
<b>Total Current Liabilities</b>	<b>999,268</b>
<b>Long-Term Liabilities</b>	
Notes payable	140,730
Less: Current portion included above	6,205
<b>Fund Balance</b>	
Unappropriated	4,337,386
<b>Total</b>	<b>\$5,471,179</b>

**Statement of Changes in Fund Balance  
for the Months Ended March 31, 1986**

<b>Unappropriated</b>	
Beginning of period	\$4,307,132
Excess of revenue over expenses	30,254
End of period	<u>\$4,337,386</u>

**Statement of Revenues and Expenses  
for the Months Ended March 31, 1986**

<b>Operations</b>	
Revenue	\$261,281
Expenses	312,066
Excess of Expenses over Revenue	
From Operations	<u>(50,785)</u>
<b>JOURNAL</b>	
Revenue	26,760
Expenses	31,734
Excess of Expenses over Revenue	
From JOURNAL	<u>(4,974)</u>
<b>Annual Meeting</b>	
Revenue	17,420
Expenses	2,512
Excess of Revenue over Expenses	
From Annual Meeting	<u>14,908</u>
<b>Other Revenue (Expenses)</b>	
Excess of reimbursement over expenses for subsidiary	71,105
Net Excess of Revenues over Expenses	<u>\$ 30,254</u>

**Schedule of Revenues  
for the Months Ended March 31, 1986**

<b>Operations</b>	
Membership dues	\$156,546
Interest	17,822
Commissions	17,635
Building lease	5,400
Membership directory sales and advertising	16,772
Computer	47,106
Total Revenue from Operations	<u>261,281</u>
<b>JOURNAL</b>	
Subscription and sales	7,780
Advertising	18,980
Total Revenue from JOURNAL	<u>26,760</u>
<b>Annual Meeting</b>	
Exhibit fees	17,420
Total Revenue from Annual Meeting	<u>\$ 17,420</u>

**Schedule of Expenses  
for the Months Ended March 31, 1986**

<b>General Membership Expenses</b>	
Salaries	\$ 76,199
Awards and contributions	2,224
* Councils	18,424
Depreciation and amortization of leased equipment	5,046
Dues and subscriptions	2,059
Equipment rental	8,573
Insurance	9,494
In-state travel	1,204
Interest	4,311
Legal and professional	3,085
Office supplies	10,693
Out-of-state travel and AMA convention	15,242
Payroll taxes	6,156
Postage and shipping	15,832
Repairs and maintenance	2,123
Services	833
Staff and officers	17,137
Telephone and utilities	10,682
Other general expense	2,336
Newsletter	2,284
Computer maintenance contract	4,959
Computer supplies	2,586
Directory	17,546
Auxiliary	1,953
Return-to-Reason	35,391
Special Olympics	(7,549)
OSMA Film Project	29,910
Physicians Recovery Program	13,333
	<u>312,066</u>
Excess of reimbursement over expenses for subsidiary	71,105
Total General Membership Expenses	<u>\$240,961</u>

**Council Expenses \* (included in above)**

Governmental activities	6,706
State legislation	16,978
Professional and public relations	3,275
Medical education	(255)
Medical services	299
Member services	(9,047)
Public and mental health	99
Hospital medical staffs	369
Total Council Expenses	<u>\$ 18,424</u>

**JOURNAL Expenses**

Salaries	\$ 9,000
Printing	15,368
Advertising	2,980
Art work	1,909
Proofreading	318
Supplies	1,124
Operating	1,035
Total JOURNAL Expenses	<u>31,734</u>

**Annual Meeting Expenses**

Exhibit	513
Planning	146
Miscellaneous supplies	153
Entertainment	1,200
Sports activities	500
Total Annual Meeting Expenses	<u>\$ 2,512</u>

Decked out for the Inaugural Ball are Kelsey Walters, new president of the OSMA Auxiliary, and her husband Roland A. Walters III, MD, of Oklahoma City.



**Schedule of Expenses  
Budget Projections  
1986**

**General Membership Expenses**

Salaries	\$ 352,300
Awards	2,000
* Councils	199,700
Data processing	2,500
Depreciation and amortization	48,000
Dues and subscriptions	5,000
Equipment rental and expense	32,500
In-state travel	3,500
Insurance	35,000
Interest	16,400
Legal and professional	12,000
Loss prevention project	50,000
Office supplies	21,000
Out-of-state travel and AMA convention	80,000
Payroll taxes	25,000
Pension costs	25,000
Physicians recovery program	50,000
Postage and shipping	35,000
Repairs and maintenance	10,000
Services	3,500
Staff and officers	39,500
Telephone and utilities	45,000
Other general expense	2,000
Auxiliary	5,000
Resident activities	1,000
Student activities	10,000
AMA delegates	5,000
OSMA directory	12,500
Computer maintenance	8,000
<b>Total Membership Expenses</b>	<b>1,136,400</b>
<b>JOURNAL Expenses</b>	<b>130,000</b>
<b>Annual Meeting Expenses</b>	<b>50,000</b>
<b>Total Expenses</b>	<b>\$1,316,400</b>

**Council Expenses \*** (included in figures above)

State governmental activities	\$ 65,000
Federal governmental activities	27,500
Medical education	1,000
Medical services	1,000
Member services	-0-
Planning and development	3,000
Professional and public relations	100,000
Public and mental health	1,000
Hospital medical staffs	1,200
<b>Total Council Expenses</b>	<b>\$199,700</b>

**Schedule of Revenues  
Budget Projections  
1986**

**From Operations**

Membership dues	\$ 625,000
Interest and other	100,000
Building lease	29,400
Membership directory	15,000
Computer	70,000
Underwriting & Risk Management & Physician Recovery	325,000
Miscellaneous	10,000
<b>Total Revenue from Operations</b>	<b>1,174,400</b>

**From JOURNAL**

Subscriptions and Sales	32,000
Advertising	70,000
<b>Total Revenue from JOURNAL</b>	<b>102,000</b>

**From Annual Meeting**

Exhibit fees	25,000
Tickets & Registration	25,000
<b>Total Revenue from Annual Meeting</b>	<b>50,000</b>
<b>Total Revenue</b>	<b>\$1,326,400</b>

<b>Total Revenue</b>	<b>\$1,326,400</b>
<b>Total Expenses</b>	<b>1,316,400</b>
<b>Total Revenue over Expenses</b>	<b>\$ 10,000</b>

Year	Profit/Loss	State Dues
1976	\$ 5,008	\$150
1977	14,831	150
1978	(5,548)	150
1979*	57,432	180
1980	4,666	180
1981	52,694	180
1982	45,484	210
1983	(58,414)	210
1984	96,102	210
1985	(83,663)	210
*Changed fiscal years		

**Membership Report  
May 1, 1986**

		As of 12/85
Regular Membership	3,178	3,128
Affiliate Members	10	10
Life Members	357	351
Junior (Residents & Students)	537	497
Hardship Members	1	3
	4,083	4,184
Pending Members	107	195
	4,190	4,184

There are 462 non-members listed on the OSMA physician file.



**Outgoing Auxiliary President Mary Ann Deen reports to the House of Delegates on the Auxiliary's activities during the past year.**

## Report of the COMMITTEE ON APPROPRIATIONS AND AUDITING

Subject: **Annual Report**

Presented by: Raymond L. Cornelison, Jr., MD, Chairman  
Secretary-Treasurer

Referred to: Reference Committee I

### Audit

The Committee has reviewed the 1985 Audit prepared by Price Waterhouse. The association's accounts properly reflect the fiscal details of the association's activities.

Assets total \$5,551,223, down from last year's \$5.8 million, due primarily to an \$80,000 loss in the association's operations and a \$200,000 loss in PLICO. PLICO's loss is not a "real" loss since it is based on projected payouts on future liability claims. OSMA's loss was projected and was created for the most part by non-recurring expenditures.

Liabilities show an unappropriated fund balance of \$4.3 million, of which \$3.4 million is the association's equity in PLICO.

The current assets reflect a cash balance of about \$475,000 and dues receivable of \$644,000.

The Schedules of Revenue and Expenses are in order and appear to accurately allocate income and expense.

### Conclusion

It is the opinion of the committee that the association's books follow generally accepted accounting principles, and that the audit is complete and accurately details the association's financial operations.

Respectfully submitted,  
Raymond L. Cornelison, Jr., MD, Chairman  
John R. Alexander, MD  
Kent Braden, MD  
Jodie L. Edge, MD  
Marcus B. Shook, MD

## Report of the COUNCIL ON PLANNING AND DEVELOPMENT

Subject: **Annual Report**

Presented by: James B. Eskridge III, MD, Chairman  
Referred to: Reference Committee I

### Introduction

The Council on Planning and Development is charged with the responsibility of studying and recommending long-range objectives for the OSMA and assessing and making recommendations regarding the resources and programs necessary to reach the objectives. Council membership consists of all of the OSMA's general officers, the delegates and alternate delegates to the AMA, and the chairmen of all other association councils and committees. This puts it in the position of having access to the best possible information for long-range objective study.

By tradition, the Council meets twice each year, once in the early fall and then in the spring, some 30-60 days prior to the OSMA Annual Meeting. At this latter meeting, the Council reviews the House of Delegates report prepared by each of the other councils in addition to any proposed resolutions to be considered by the House.

The following report is broken down by council and committee, where appropriate, with comments and/or recommendations regarding future activities. In addition, it also contains comments regarding five major areas of concern for the Association's future activities.

### Council on Member Services

During its fall meeting, the Council heard a report from the Council on Member Services regarding the creation of a for-profit corporation, as previously authorized by the OSMA House of Delegates. It was the Council's recommendation that the Member Services Council should immediately begin implementation of the new corporation.

It was also reported that the Council on Member Services spends a great deal of its time working on underwriting problems for PLICO in its capacity as the Association's Underwriting Committee. Concern was expressed that OSMA members did not fully understand PLICO coverage limitations, especially in regard to physician activities in HMOs and PPOs. (See recommendation #1 at the end of this report.)



Paul L. Patton, executive director of the Tulsa County Medical Society, seems determined not to miss a word during the House's Opening Session.

### **Council on Medical Services**

It was reported that the Council on Medical Services is in the process of reimplementation of the Peer Fee Review activities and that county medical societies are being encouraged to handle problems at local levels. It was pointed out at the fall meeting that one problem immediately encountered by the new fee review mechanism was the limitation that fee complaints could be heard only if brought by patients. The Planning and Development Council felt that there needed to be some provision to allow other types of fee complaints to be heard, such as those involving Workers' Compensation patients where the employer is the actual payor, not the patient.

At the fall meeting, it was the Planning and Development Council's recommendation to the Member Services Council that it should reconsider the fee review limitation and reword the rules to allow exceptions.

The main discussion at the spring meeting was a concern on the part of the chairman of the Medical Services Council that there was a misunderstanding of the Council's actual functions and responsibilities. It was reported that occasionally the Council was being asked to serve in the capacity of an ethics review.

In the discussion that followed it was pointed out that the OSMA had no real mechanism, other than the Grievance Committee, where questions of ethics could be brought for consideration and advice. The Planning and Development Council discussed the possibility of creating a new OSMA council to consider questions of ethics and physician competency. Hospital medical staffs are frequently faced with judging the medical or surgical competency of a physician, but there are no guidelines to follow or organizations to assist in such an undertaking.

After considerable discussion, it was the recommendation of the Planning and Development Council that the House of Delegates of the OSMA should consider the establishment of a special Council on Ethics and Competency to handle such questions. The competency portion would cover diagnostic competency, language comprehension, psychological and human relations, ethics comprehension, etc. The ethics part of the Council could handle any question of medical ethics brought to it by a member of the Association for hearing.

(See Resolution #21.)

### **Council on Medical Education**

The Planning and Development Council wishes to commend the Council on Medical Education for its diligent work in regard to CME Accreditation. It was reported that there are now nine hospitals in the state of Oklahoma with CME Accreditation. In addition, the Council on Medical Education is continuing to monitor physician production in the state.

### **Council on Public and Mental Health**

The primary discussion at the fall meeting in regard to this Council's report was the need for a knowledgeable group of physicians and other persons to speak for the OSMA in regard to the many troublesome questions on the subject of AIDS.

At the present time, there is no scientific or medical body in the state of Oklahoma that can be consulted by state government, the mass media, or concerned individuals, regarding the medical aspects of AIDS. It is the recommendation of the Planning and Development Council that the OSMA should appoint a special task force on AIDS. (See recommendation #2 at the end of this report.)

### **Physician Recovery Committee**

It was reported to the Planning and Development Council that the Physician Recovery Committee is currently following nearly 100 physicians in treatment and that it is working very closely with the Oklahoma Board of Medical Examiners. Also, in late 1985, it began to work with the Oklahoma Osteopathic Association. It's estimated that in the near future this committee will probably require a full-time medical director, and it is conceivable that future operations could cost as much as \$100,000 a year to help offset the cost of treatment and to support physicians during their treatment period, while they are not productive.

A few years ago, the OSMA Board of Trustees established a revolving fund of \$30,000 to be utilized to assist physicians that were in trouble when they found it necessary to leave their practice for a short period of time. Currently, some \$10,000 is loaned to such physicians. The Association is maintaining a separate set of books so it can keep track and control of these funds.

At its fall meeting the Planning and Development Council recommended that the Committee prepare a detailed budget and make an appropriate fund request through the OSMA's Budget and Audit Committee.

In addition, the Planning and Development Council commended the activities of the Committee's medical director, the Committee Chairman, and the Committee as a whole.

### **Council on Professional and Public Relations**

The Planning and Development Council viewed the new OSMA film produced by the Professional and Public Relations Council. It has recommended to the Board of Trustees that the film be given the widest possible distribution to affiliated societies (other state medical associations, county medical societies, etc.) and any other interested parties and organizations at a minimum charge, but accompanied by a solicitation for possible contributions to offset the cost of the film production. It is also recommended that the Board consider a special study of the possibility of future films, with emphasis on budgetary considerations.

In addition to the film production, the Professional and Public Relations Council also conducted its usual activities of creating public service announcements, a monthly newsletter, creation of a speakers bureau, and a new membership brochure. The Planning and Development Council recommended that special consideration should be given to the location of the speakers bureau in both Oklahoma City and Tulsa to meet local commitments.

### Tort Reform

The Council heard several reports during its two meetings on the subject of tort reform and about the OSMA's participation in the Return to Reason Coalition. These will not be discussed here since a special report on the subject will be made to the House of Delegates separately.

### Council on Hospital Medical Staffs

During its 1985 Annual Meeting, the OSMA House of Delegates adopted bylaws amendments that would create three new Sections for the House of Delegates. These are: a Section on Hospital Medical Staffs, a Section on Resident Physicians, and a Medical Student Section. The Council on Hospital Medical Staffs reported to the Planning and Development Council that it had now organized itself into the Hospital Medical Staff Section, adopted appropriate bylaws, and awaited House of Delegates action in 1986 for adoption of the appropriate constitutional amendments that would activate the Section.

### House of Delegates Section Creation

As reported in the Hospital Medical Staff Council above, in 1985 the House of Delegates adopted appropriate bylaws for three new sections. In order to activate the new sections, it will be necessary for the House to adopt an appropriate amendment to the OSMA Constitution at this meeting, May 1986.

It came to the Planning and Development Council's attention, however, that there was an inconsistency in county medical societies regarding student and resident physician dues. The Planning and Development Council adopted a resolution recommending that county medical societies be encouraged to modify their dues to medical students and resident physicians in order to lower any possible barrier to OSMA membership created by a dues structure. Appropriate letters were sent to all county medical societies where there were students and/or residents and a positive response was received back in almost all instances.

### American Medical Association Activities

During its fall meeting, the Council held a discussion of the possibility of creating a special fund to assist Oklahoma physicians that might be interested in running for the various elective positions in the American Medical Association. It was proposed that a minimum of \$5,000 per year be put into such a special fund for use as needed. The fund would be controlled by the OSMA's Board of Trustees.

The elected positions of the AMA are usually hotly contested and require extensive campaigning. It was the Council's feeling that it would be appropriate for the OSMA to underwrite the cost of such campaigns if ever it was determined that there was a definite possibility that an Oklahoma physician might be elected. (See recommendation #3 at the end of this report.)

### Tenure of OSMA Officers

A special ad hoc committee report on tenure of OSMA officers was considered by the Planning and Development Council at its fall meeting. Following a lengthy discussion the Council adopted a motion to recommend to the OSMA Board of Trustees that it should encourage more than one nominee for the various general offices and AMA delegate and alternate delegate positions. This recommendation was given to the Trustees during their November meeting.

### OSMA Annual Meeting

A discussion of the future of the OSMA Annual Meeting was held during the spring Council meeting. It was pointed out that there has been a steadily declining attendance at the Annual Meeting for the last several years and that the scientific programs, in particular, were not being well attended. Most of the individuals attending the Annual Meeting attend because of positions as Officers, Trustees, or Delegates.

It was generally agreed that most physicians attend specialty society programs or specific scientific programs for their continuing medical education. Many state medical associations have long since discontinued scientific programs and now conduct annual meetings strictly for business purposes.

It was the recommendation of the Council that the House of Delegates should consider, via resolution, modifying the OSMA's Annual Meeting to a business session only, while discontinuing the scientific program and exhibits. The Association's staff was instructed to prepare a special resolution for consideration by the House and to attach to it a set of alternative plans for consideration that would result in a shortened meeting.

It is the Planning and Development Council's recommendation that this resolution be given serious consideration. (See Resolution #20.)

### OSMA Long-Range Goals

The Planning and Development Council, 1984, had identified five areas of priority activity. During the fall 1985 meeting, the Council considered each one of these goals.

A. Alternative Delivery Systems: The Planning and Development Council adopted a resolution urging the President of the OSMA to take the question of the legality of the John Hancock Insurance Company and Blue Cross Company interfering in the doctor-patient relationship to the State Insurance Commissioner for review. Failing a favorable action, the Association should seek appropriate legal measures to correct the situation.

(Facing) Lights are dimmed in the House of Delegates for the premiere of the OSMA's new thirty-minute film, *Preserving Tradition, Embracing Change*.

The above motion was adopted when it was explained that John Hancock and Blue Shield had provisions in some of their contracts requiring an attending physician to get up to a two-week pre-hospitalization certification before the company would pay. In addition, Blue Cross had stated in its publicity that failure on the part of the physician to do so would mean that not only would Blue Cross not pay the bill, but that the patient would not be required to pay the physician's bill.

After some delay, an appropriate letter was prepared and sent to the State Insurance Commissioner. As of early April, a response had been received from John Hancock, but Blue Cross and Blue Shield still had the questions under consideration.

**B. Malpractice Crisis:** A discussion was held regarding the possibility of seeking tort reform legislation in some future legislative session. As an outgrowth of this discussion, the OSMA became involved in the Return to Reason Campaign.

**C. Eroding Image of the Physician:** The use of the new film produced by the OSMA to be used for this area was given discussion, along with similar activities from the American Medical Association. It was recommended by the Planning and Development Council that the OSMA Board of Trustees should consider commitment to a long-term, multifaceted public relations effort regarding the physician's public image.

**D. Physician Oversupply:** Following a discussion of this priority area, it was moved and adopted by the Planning and Development Council to recommend that the OSMA Board of Trustees commend the Regents for Higher Education and encourage them to raise the standards of admission of medical school entrance even if it resulted in reduction of class size.

**E. Government Regulation and Intrusion:** While this area received a great deal of discussion, the Planning and Development Council had no specific recommendations.

### **Additional Board of Trustees Recommendations**

In addition to the various items mentioned in this report, the Planning and Development Council also made numerous recommendations to the Board of Trustees. Most of these recommendations will be covered in the supplemental report of the Board of Trustees to the House of Delegates. But for reporting purposes, the following is a brief listing of the areas taken directly to the Board of Trustees.

**A. OSMA President's Compensation:** It was recommended that the OSMA President's compensation be left at its current level.

**B. Membership Value:** It was recommended to the Board of Trustees that it establish a task force or ad hoc committee to study mechanisms that would encourage physicians to join the Association and the AMA and to explain to them the dollar value of their dues.

**C. Membership Symbol:** It was recommended that the OSMA consider the creation or development of a symbol that physicians might use on their letterhead, office, billings, etc., indicating that they are members of the OSMA.

**D. Hospital Directories:** It was pointed out that hospitals are now beginning to develop directories of services and hospital staff members for distribution to the general public, usually in relation to an HMO or PPO organization. It was the Planning and Development Council's feeling that this type of publicity is not prohibited by either the OSMA or the AMA.

**E. Return to Reason Coalition:** A complete and separate report on the tort reform and Return to Reason Coalition is being submitted to the OSMA House of Delegates. However, it was the Planning and Development Council's recommendation to the Board of Trustees, during the tort reform legislative period, that OSMA Executive Director David Bickham be instructed to closely monitor the activities of the coalition and the progress of the various tort reform bills and to utilize his best judgment, on the spot, in all negotiations regarding legislation.



F. Statewide HMO/IPA: Several other state medical societies have now organized their own statewide HMO or IPA organizations. The Council has recommended to the Board of Trustees that it give serious consideration to the formation of an ad hoc committee to investigate the formation of such a statewide organization for Oklahoma.

G. Unified States Organization: At the present time, there are six states that require physician members to belong to all levels of organized medicine, ie, the American Medical Association, the state association, and the county medical society. These are Oklahoma, Illinois, Mississippi, Kansas, Utah, and Virginia. It was recommended that Oklahoma and Illinois, the two states having unified membership for the longest period of time, should form an organization of unified states and the OSMA staff should be directed by the Board of Trustees to prepare a charter or Articles of Incorporation for consideration by the two states.

### Recommendations

(1) It is recommended that the House of Delegates urge the OSMA Underwriting Committee (Member Services Council) and PLICO to implement an educational program to explain PLICO coverage limitations to insured physicians through the PLICO Newsletter, OSMA Newsletter, OSMA JOURNAL, and direct mail. This publicity campaign should also be used to stress the importance of having PLICO legal counsel review HMO, PPO, and IPA contracts before an insured physician signs.

(2) It is recommended that the House of Delegates instruct the OSMA President that a task force or ad hoc committee on AIDS should be created to consult with the Governor, State Legislature, mass media, etc.

(3) It is recommended that the OSMA House of Delegates consider the creation of a special fund for the purpose of supporting OSMA member physicians wishing to run for elective positions in the American Medical Association. The funds would be under the direction and control of the Board of Trustees and made a part of the regular budgetary process. The Trustees should be authorized to determine how the funds should be utilized in order to maximize the election potentials.

Respectfully submitted,  
James B. Eskridge III, MD  
Chairman  
Council on Planning and Development

## Report of the CONSTITUTION AND BYLAWS COMMITTEE

Subject: Annual Report  
Presented by: Floyd Miller, MD, Chairman  
Referred to: Reference Committee I

### Introduction

The Constitution and Bylaws Committee is charged with the responsibility of considering all proposed amendments to the Association's Constitution and Bylaws to assure that they are in appropriate form and, if adopted, do not cause conflicts with other portions of the two documents. The Committee may originate proposed amendments, or consider amendments proposed by component societies or individual members of the Association and shall then present them with its recommendations to the House of Delegates for consideration. The Committee has received no proposed amendments to be considered by itself for this year. However, the creation of three special sections by the House of Delegates during the 1985 meeting will require that the OSMA Constitution be amended during the Opening Session of the 1986 House of Delegates. By the time this report is considered by the House of Delegates Reference Committee, the Constitution will have already been amended or the proposed amendment will have failed.

### House of Delegates Sections

In early 1985, the OSMA Planning and Development Council recommended that the House of Delegates consider creating three delegate sections with full voting power. These would be a Medical Student Section, Resident Physician Section, and Hospital Medical Staff Section.

During its 1985 meeting, the House of Delegates adopted appropriate bylaws amendments setting up the three sections. Each is to be treated the same as a component medical society, but is entitled to only one delegate and one alternate delegate each.

Although the 1985 House of Delegates did not have the authority to amend the Constitution, it chose to pre-adopt the necessary bylaws amendments to vitalize the creation of the three sections, and then to recommend to the 1986 House of Delegates that it adopt the constitutional changes necessary during its Opening Session. Thus, the three new sections could actually have their delegates or alternate delegates seated and participate in deliberations in 1986.

With the bylaws changes already in place, it will only be necessary for the 1986 House of Delegates to amend the OSMA Constitution as follows:

ARTICLE V of the Constitution of the Oklahoma State Medical Association is hereby amended to read:

"Section 1. The House of Delegates shall be the elective body of the Association. It shall be composed of: (1) Delegates elected by the component societies; (2) General officers of the Association; (3) All other members of the Board of Trustees and Alternate Trustees; ~~and~~ (4) Delegates and Alternate Delegates to the American Medical Association; and (5) Delegates representing Special Sections."

The underlined portion is new language.  
Appropriate and timely notice of the proposed constitutional amendment has been given to all county society presidents and to all delegates that have been reported by name to the OSMA.

Respectfully submitted,  
Floyd Miller, MD  
Chairman  
Constitution and Bylaws Committee

#### Constitution of the Oklahoma State Medical Association Student Section

##### ARTICLE ONE. NAME.

The name of this organization is the Student Section of the Oklahoma State Medical Association.

##### ARTICLE TWO. PURPOSE.

The purposes of this Section are (1) to promote the art and science of medicine and the betterment of public health and (2) to unite with other county medical societies in the State of Oklahoma to compose the Oklahoma State Medical Association.

##### ARTICLE THREE. MEMBERSHIP.

Section 1.00. All medical students in good standing shall be eligible for membership in this Section.

Section 2.00. Membership in this section is a privilege and not a right.

Section 3.00. The Section shall, within itself, and the limitations of its Constitution and By-Laws, be the sole judge of the qualifications and acceptability of any applicant for membership.

##### ARTICLE FOUR. OFFICERS, BOARD OF DIRECTORS.

Section 1.00. The officers of this Section shall be the President, President-Elect, Vice-President, and Secretary-Treasurer.

Section 2.00. The Board of Directors shall be composed of the President, President-Elect, Vice-President, Secretary-Treasurer, and eight (or nine) other Directors to be elected and to serve in the manner set forth in the By-Laws.

Section 3.00. The Board of Directors shall have the general direction of the affairs of the Section, shall exercise the powers and authorities appertaining to it as set forth in the By-Laws, shall act for the Section in the interim between meetings of the Section except as otherwise specified, and shall have supervision over all committees, officers, and employees.

##### ARTICLE FIVE. MEETINGS.

The annual meeting of the Section shall be held during the last sixty days of each year. Other meetings shall be held as provided by the By-Laws. Adequate notice of the date, time, and place of all meetings shall be given to each member by the Secretary-Treasurer.

##### ARTICLE SIX. FINANCES.

The Section shall have the authority to levy dues and assessments as it considers proper for the conduct of the business of the Section.

##### ARTICLE SEVEN. ETHICS.

The Principles of Ethics of the American Medical Association currently in force and effect, together with those subsequently enacted, shall be those of this Section, and shall govern the conduct of its members.

##### ARTICLE EIGHT. BY-LAWS.

The Section shall have the authority to adopt By-Laws for the governing of the organization.

##### ARTICLE NINE. AMENDMENTS.

This Constitution may be amended at any regular meeting of the Section by a two-thirds affirmative vote of the members present and voting, providing that such proposed amendments shall have been read at the preceding meeting of the Section for business purposes, except that reading of the proposed amendment may be waived by a two-thirds vote of the members present, and a copy of same shall have been sent to each member of the Section at least ten days prior to the date at which action is to be taken. Amendments will be introduced by resolution of the Board of Directors. Any five members may propose an amendment to the Board of Directors.

##### ARTICLE TEN. FORCE AND EFFECT.

This Constitution supersedes and repeals all previous Constitutions, and shall be in effect from the moment of its legal adoption by the Section. Any By-Law, resolution, or enactment in conflict with the provisions of this Constitution is declared to be without effect.

#### By-Laws of the Student Section of the Oklahoma State Medical Association

##### CHAPTER ONE. MEMBERSHIP.

Section 1.00. Basic Requirements. A candidate for membership shall be a student in good standing in a college of medicine.

Section 1.01. Active Members. Members whose dues and assessments are fully paid shall be Active Members. Such members shall have the full privileges of Section membership, including the right to hold office, if eligible under the provision of Chapter III, Section 1.012, and vote.

Section 2.00. Application and Election. Application for membership shall be made in triplicate on the form provided by the Oklahoma State Medical Association. The application shall bear the endorsement by signature, of one active member of the county society in which the school is located.

The application shall be read at the next regular meeting of the county society in which the school is located. The rules of that county society will prevail.

Section 3.00. State and National Membership. All members of the Student Section of the Oklahoma State Medical Association are required to be members of the Oklahoma State Medical Association and the American Medical Association.

Section 4.00. Tenure. A member shall retain his membership as long as he complies with the provisions of the Constitution and By-laws and with the Principles of Ethics of the American Medical Association and is a medical student in good standing.

Section 5.00. Offense and Termination.

Section 5.01. Causes. A member who is guilty of any of the following as determined by the Oklahoma State Medical Association Student Section:

- (a) a criminal offense involving moral turpitude;
- (b) gross misconduct as a physician or citizen;
- (c) violation of the Principles of Medical Ethics;
- (d) the willful commission of any act tending to defeat the aims, purposes, or objects of this Section, or to bring the Section into disrepute;
- (e) the willful refusal to adhere to the Constitution and By-Laws of the Section;
- (f) the giving of any testimony in a court of law or in an administrative proceeding which in the opinion of the Section is reckless, willfully false or fraudulent, or is not in keeping with the dignity or scientific standards of the medical profession;
- (g) the violation of Federal or State Narcotic regulations;

shall be liable to (1) admonition, (2) suspension, or (3) expulsion. Membership in the Section shall automatically be terminated for a member convicted of a felony.

Section 6.00. Transfer. A member in good standing who moves his residence from Oklahoma County or Tulsa County shall be issued a Certificate of Transfer by the Secretary-Treasurer.

##### CHAPTER TWO. MEETINGS.

Section 1.00. Regular Meetings. There shall be at least two regular meetings of the Section, one of which shall be the annual meeting. The time and place shall be determined by the Board of Directors of OSMA. Consideration shall be given to preparation for the Oklahoma State Medical Association Annual Meeting as specified in Chapter Six, Section 1.

Section 2.00. Annual Meeting. The annual meeting will be the same as the OSMA Annual Meeting.

Section 3.00. Quorum. Ten percent of the voting members shall constitute a quorum for the dispatch of business at a meeting of the Section.

##### CHAPTER THREE. ELECTION — OFFICERS, DIRECTORS, AND DELEGATES.

Section 1.00. Nominating Ballot.

Section 1.01. Between ten and thirty days before the mid-year meeting there shall be mailed to each eligible voting member an official nominating ballot.

Section 1.02. Election of officers will be by voice vote at the mid-year meeting.

Section 1.03. Nominations may be made from the floor at the mid-year meeting from those eligible for election as officers. Officers will be installed at the annual meeting.

##### CHAPTER FOUR. OFFICERS, RIGHTS, AND DUTIES.

Section 1.00. Rights and Duties — In General. In addition to the rights and duties provided elsewhere in the Constitution and By-Laws, the officers shall have the rights and duties respectively assigned to them in the succeeding sections of this chapter, including serving as Delegates to the Oklahoma State Medical Association.

Section 2.00. President. The President shall serve as chairman at the meetings of the Section, and of the Board of Directors, and shall perform such other duties as customs and parliamentary usage require. He or she shall appoint the members of the standing committees accordingly as terms may expire or vacancies exist during the President's term of office. The President shall appoint to serve during his/her term of office any such temporary or special committees as are necessary or ordered, the duties and functions of which will not conflict with the duties and functions of any standing committee. Within thirty days before the Annual Meeting of the Oklahoma State Medical Association, the President of the Section shall call a meeting of the Delegates as provided for in Chapter VI, Section 1.01.

Section 3.00. Vice-President. The Vice-President shall assist the President in the discharge of his duties and shall preside at all meetings from which the President is absent. In addition, he shall have such other duties as the Board of Directors shall designate.

Section 4.00. President-Elect. The President-Elect shall, by active aid to the President and by membership on the Board of Directors during his or her term of office, so conduct himself/herself as to obtain the greatest possible acquaintanceship with the affairs and personnel of the Section so as to enable him/her efficiently to fulfill the office of the President.

Section 5.00. Secretary-Treasurer. It shall be the duty of the Secretary-Treasurer:

Section 5.01. To record the minutes of the Section and of the Board of Directors.

Section 5.02. To be custodian of all records, books, papers, and Seal belonging to the Section.

Section 5.03. To carry on the official correspondence of the Section, including such matters as notifying members of meetings, officers of their election, committees of their appointments and duties, and all notices required by the Constitution and By-Laws or by law.

Section 5.04. To keep a record of all members.

Section 5.05. To take charge and keep a correct account of receipts and disbursements of all monies belonging to the Section, a statement of which shall be presented at the Annual Meeting. (The receipts and disbursements for the month of December may be estimated.) At a subsequent regular meeting he/she shall present the auditor's report for the preceding year. He/she shall demand and receive all moneys due the Section and shall preserve, for the benefit of the Section, all donations and other property and keep an exact record of same, together with the names of the donors. Prior to December 31st, annually, he/she shall notify the members as to the dues that are due and payable by them on January 1st. On March 15th, following, he/she shall place on the roll of delinquent members all members who have failed to pay their dues by that date and shall report this list of delinquent members to the Board of Directors at its next meeting. He/she shall forward to the Secretary-Treasurer of the Oklahoma State Medical Association monthly such dues owing the Association for the current or previous years as have been collected during the previous month from the individual members and also the names and addresses of the members whose dues are remitted. He/she shall not pay out any money from the treasury except by check nor dispose of any other property of the Section except by order of the section.

Section 5.06. To disburse any funds for special purposes not budgeted, as directed by action of the Board of Directors.

Section 5.07. To invest the funds of the Section at the direction of the Board of Directors.

Section 6.00. Vacancies. Vacancy of the office of President of the Section created by death, resignation, removal, or disqualification of the President shall be filled immediately and automatically by the Vice-President, who shall become President for the unexpired term of office. Vacancy of the office of Vice-President or any other office shall be filled by election of one of the Directors at a special meeting of the Board of Directors called at the earliest time after the vacancy occurs, or at the next regular meeting.

## CHAPTER FIVE. BOARD OF DIRECTORS

Section 1.00. The Board of Directors shall be the Officers and Chairmen of the standing committees.

Section 2.00. Meetings, Quorum. The Board of Directors shall meet monthly, ordinarily on the third Tuesday of each month, unless otherwise determined by the President of the Section. The President shall fix the time and place of such meetings. Seven members of the Board shall constitute a quorum for the transaction of official business.

## CHAPTER SIX. DELEGATES AND ALTERNATE DELEGATES.

Section 1.00. Election. The Section shall elect Delegates and Alternate Delegates to the Oklahoma State Medical Association in a number to which it is entitled as determined by the provisions of the By-Laws of the Oklahoma State Medical Association.

## CHAPTER SEVEN. DUES AND ASSESSMENTS.

Section 1.00. Dues. The annual dues of the Oklahoma State Medical Association Student Section shall be set by action of the Board of Directors and approved by the membership at the Annual Meeting of the Section. The recommendations of the Board of Directors shall be accompanied by a tentative budget showing the contemplated sources of income and disbursement of funds. The levy of dues shall include the annual membership dues of the Oklahoma State Medical Association and the American Medical Association.

Section 2.00. Payment of Dues. Dues shall be payable on January 1st of the year for which levied, and shall become delinquent if not paid on or before February 28th of that year.

Section 2.01. Suspension. Failure to pay dues by February 28th shall result in automatic suspension of membership in the Section. A member suspended for non-payment of dues or assessments may be reinstated upon full payment of the amount due with approval of the Board of Directors.

Section 2.02. Forfeiture of Membership. Failure of a suspended member to pay dues by May 31st shall result in automatic termination of membership in the Section as of that date.

## CHAPTER NINE. COMMITTEES.

Section 1.00. The committees shall be the same as those standing councils of the OSMA and such ad hoc committees as may be appointed by the president.

Section 1.01. Public Relations Committee. The Public Relations Committee shall engage in a program of general public relations designed to represent the Section in all public matters affecting the profession.

Section 1.02. Orientation and New Member Committee. The Chairman of this Committee shall organize and present at least twice each year at separate times, comprehensive indoctrination sessions for applicants for active membership in this Section, and will certify that the candidate has attended one of the orientation sessions provided by this Section. He shall cause each applicant for active membership to be notified of the orientation session attendance requirement, providing the applicant with the time and place of the next available session.

Section 1.03. Other Committees. The President shall be empowered to appoint, with the approval of the Board of Directors, such other committees as shall be needed to assist in the efficient operation of the Section.

Section 2.00. Resignation from Committees.

Section 2.01. Voluntary. Any committee member may resign voluntarily by notice to the President of the Section.

Section 2.02. Automatic Resignation. Any committee member shall be automatically relieved of his position on said committee by missing two consecutive meetings of the committee without a legitimate excuse. The Chairman of the committee shall be the sole judge of the "legitimate excuse." The member must submit his or her own excuse in writing within two weeks after any absence.

Section 2.03. Replacement of Committee Members. The President may appoint a new member to any committee at any time at his own discretion unless otherwise specified by the Constitution and By-Laws.

Section 2.04. Dismissal of Committee Member. The President may at any time dismiss any member of any committee at his/her own discretion, unless otherwise specified by the Constitution and By-Laws.

## CHAPTER TEN. AMENDMENTS.

These By-Laws may be amended at any regular meeting of the Section by a two-thirds affirmative vote of the members present and voting, providing that such proposed amendment shall have been read at the preceding meeting of the Section for business purposes, and a copy of same shall have been sent to each member of the Section at least ten days prior to the date at which action is to be taken. Any five members may submit an amendment to the Board of Directors or it may be introduced by resolution of the Board of Directors.

## CHAPTER ELEVEN. EFFECT AND PRESERVATION.

These By-Laws as herein codified and amended shall be in effect from the moment of their legal adoption by the Section.

Adopted May 11, 1985.



Steven L. Saltzman, MD, panel moderator for the Obstetrics/Gynecology section of the Scientific Program, introduces the first speaker. Dr Saltzman is associate professor and chairman of the OB/GYN department of Tulsa Medical College, as well as a clinical assistant professor of family medicine.

Oklahoma State Medical Association  
Hospital Medical Staff Section  
Bylaws

A. HOSPITAL MEDICAL STAFF SECTION.

The Hospital Medical Staff Section of the Oklahoma State Medical Association (OSMA) shall be comprised of OSMA member physicians selected by physician members of the medical staffs of hospitals. The medical staff of each licensed hospital in the state shall be entitled to one voting representative in the section. The purpose of the section is to provide a direct means to address the relationship among members of the OSMA, hospital medical staffs, and hospitals.

B. GOVERNING COUNCIL.

There shall be an eleven-member Governing Council for the Hospital Medical Staff Section. The council shall consist of the officers and six members-at-large of the section. All members of the Governing Council must be members of the OSMA. The section officers shall be as follows:

1. **Chairman.** The Chairman shall be appointed annually by the President of the OSMA and shall preside at all meetings of the Governing Council and the business meetings of the Hospital Medical Staff Section.

2. **Vice-Chairman.** The Vice-Chairman shall preside at meetings of the Governing Council or the business meetings of the Hospital Medical Staff Section, in the absence of the Chairman or at the request of the Chairman.

3. **Secretary.** The Secretary shall maintain such records as are required or advisable for the conduct of the activities of the Hospital Medical Staff Section.

4. **Delegate and Alternate.** The Delegate and Alternate Delegate shall be officers and shall represent the section in the OSMA House of Delegates.

5. **Terms of Office.** The Governing Council members, except the Delegate and Alternate Delegate, shall serve a term of two years, from June 1 through May 31 and the Delegate and Alternate Delegate must be elected each year and shall serve staggered terms. The Delegate or Alternate Delegate in the absence of the Delegate, shall be authorized to be seated and vote during all regular, interim, or special sessions of the OSMA House of Delegates.

6. **Vacancies.** Any vacancy on the Governing Council shall be filled by appointment of the Chairman until the next annual election. In the absence of the Chairman, the Vice-Chairman shall appoint. A vacancy in the chairmanship shall be filled by appointment of the President of the OSMA.

C. CONDUCT OF BUSINESS.

The Hospital Medical Staff Section and Governing Council shall be guided by the conduct of business pursuant to rules of procedure adopted by the Governing Council and by *Roberts Rules of Order*.

D. ANNUAL MEETING.

The Hospital Medical Staff Section shall have the authority to meet as often as deemed appropriate, but shall meet at least once annually prior to the annual session of the OSMA House of Delegates at a time and place approved by the Executive Director of the OSMA, to carry out the following activities:

1. **Elections.** The section shall elect a Vice-Chairman, Secretary, six members-at-large, and a Delegate and Alternate Delegate to the OSMA House of Delegates.

2. **Resolutions.** The section shall have the authority to submit resolutions to the OSMA House of Delegates through its elected Delegate.

3. **Reports.** The section shall have the authority to commission and to hear such reports as may be appropriate.

4. **Voting.** The section shall have the authority to consider and vote upon such matters as may properly come before the meeting.

5. **Quorum.** A quorum for any meeting of the Hospital Medical Staff Section shall be no less than 20 individual hospital representatives.

E. GOVERNING COUNCIL MEETING.

The Governing Council shall meet as needed on call of the Chairman or at the written request of two or more council members. The council shall fix the agenda for items to be considered during the section meetings. During the interim, the council shall serve as a forum for hospital staff problems and/or concerns.

F. AMENDMENTS OF SECTION BYLAWS.

These bylaws shall become effective following their ratification by a two-thirds vote of those members present and voting at a regular meeting of the section, and upon approval of the OSMA Board of Trustees. These bylaws may be amended by a two-thirds vote of members present and voting at a regular meeting of the section, and approved by the OSMA Board of Trustees.

## Report of the PHYSICIANS LIABILITY INSURANCE COMPANY

Referred to: Reference Committee I

Our insurance company, Physicians Liability Insurance Company, completed six years of operation on December 31, 1985. Our company continues to excel in the professional liability and group medical and dental insurance lines. This speaks well for the physicians of Oklahoma, considering the worsening national experience in these lines.

The strong performance of PLICO can be attributed to an excellent plan and alert, sound supervision by the PLICO Board of Directors. However, the unity, cohesiveness, and strength of the Oklahoma State Medical Association is the principal reason for PLICO's success.

### Professional Liability Program

During 1985, PLICO's reinsurance carrier, General Reinsurance Corporation, decided that they would no longer reinsure occurrence-type professional liability policies.

They encouraged PLICO to convert to a "claims-made" policy. Since a "claims-made" policy is inferior to an occurrence-type policy, a worldwide search was made to secure occurrence reinsurance. After several months and many man hours, occurrence reinsurance coverage was secured for 1986 through North American Reinsurance Company, a subsidiary of Swiss Reinsurance Company.

Effective January 1, 1986, PLICO changed to the national nine-class rating system for the professional liability line of business. The PLICO Board of Directors had no alternative but to proceed with the changeover because reinsurance was not available for companies not using the national rating system. Another reason for the change is the fact that there is no specialty grouping of physicians in Oklahoma that is large enough by itself to provide a statistically valid base for rate making.

In preparation for the changeover, visits were made to County Medical Society meetings and presentations were made during Loss Control Seminars to explain the nine-class system to PLICO's insureds.

An overall rate increase of 25% of gross premiums was necessary effective January 1, 1986. The rate increase along with the change to the nine-class system meant that some physicians experienced greater than a 25% increase in premiums. Even with the necessary increases and regardless of the rate classification changes, PLICO's rates are significantly less than the only competitor in Oklahoma and even less than those of other physicians practicing in other states. Furthermore, in these grim times, the only competition is currently not accepting new policyholders. In many states there is no insurance available at all to physicians regarded to be in the higher risk specialties: namely obstetrics, orthopedics, thoracic, and vascular surgeons.

From the creation of PLICO until the end of 1985, 2,168 professional liability claims had been reported. This is an increase of 540 claims since December 31, 1984. During 1985, 102 claims were paid for a total of \$11,653,719; \$5,999,713 of which was paid by PLICO and \$5,654,006 by PLICO's reinsurer.

Since PLICO's inception in 1980 through December 31, 1985, 314 claims have been paid in the total amount of \$26,391,617; \$11,863,998 of which was paid by PLICO's reinsurer and \$14,527,619 by PLICO.

The Loss Prevention Committee conducted five (5) Loss Prevention Seminars during 1985. The PLICO Board of Directors voted to make the Loss Prevention Seminars mandatory effective January 1, 1986. This will conform with pending federal standards and, hopefully, ultimately reduce this burden upon Oklahoma physicians. Since all PLICO insureds will be attending Loss Prevention Seminars, the benefits of that attendance will be spread equally among all the members, and there will be no five percent discount. However, the physicians who were entitled to the discount will continue to receive it for the three-year period.

The investment income for 1985 was \$3,475,929; which compares to \$1,924,537 in 1984. Most of the investments have been placed in A-rated corporate bonds. Investment income more than offsets the cost of management of PLICO. This leaves virtually 100 cents of every premium dollar available for claims and defense costs.

#### OSMA Assessment

During 1986 the OSMA House of Delegates voted an assessment for all members, and a policy fee for PLICO professional liability policyholders who are not members, so that all beneficiaries of PLICO's insurance program will contribute equally to the necessary surplus and capital to keep the company sound.

#### PLICO Capitalization - \$450

State law and Insurance Department regulations require \$1 million of capital and surplus for each \$100,000 of risk retained per occurrence by the company.

In 1979 when the OSMA decided to form PLICO, the House of Delegates authorized an assessment to raise the necessary capital and surplus to fund the company. The initial assessment provided \$3,500,000 in surplus, paid in three years by installments. In 1980, PLICO retained \$100,000 of the risk on each doctor and purchased reinsurance for amounts over \$100,000. In subsequent years the retention has steadily increased. In 1986, PLICO will retain \$400,000 of each physician's risk per claim; it is anticipated that if the current tight reinsurance conditions continue, next year the retention will be \$500,000. PLICO needs \$4 million in capital and surplus for 1986, and if the retention is to be \$500,000 in 1987, \$5 million is the required minimum. Insurance guidelines dictate greater surplus to premium ratios, and additional surplus will help to accomplish this objective as well.

In 1976, the OSMA entered into an insurance agreement with Hartford and Lloyd's of London that provided for a return of premium in the event losses did not equal or exceed actuarial estimates. In 1984, the OSMA received



Dala Jarolim, MD, Tulsa (left), and Ed L. Calhoon, MD, Beaver (right), welcome Bruce Chabner, MD, to Oklahoma. Dr Chabner is the director of the Cancer Treatment Division of the National Cancer Institute in Bethesda, Maryland. Dr Calhoon is one of twelve US physicians appointed by President Reagan to the National Cancer Advisory Board in 1984.

a \$1.4 million return of premium from the underwriters (Hartford and Lloyd's of London). By action of the House of Delegates, \$1 million was set aside for capitalizing PLICO. At the end of 1985, \$650,000 was contributed by OSMA. A net operating loss over the life of the company has totaled \$1,100,000. Thus, beginning in 1986, PLICO had capital and surplus of \$4.05 million. An additional \$1 million is needed if PLICO retains \$500,000 of the risk in 1987.

There are two ways to raise the necessary capital — PLICO could raise its premium and as it is earned, increase its surplus. However, the income generated would be taxable income; thus, it would take a premium of \$2 for each dollar that was put into capital. A contribution by the OSMA, in the form of an assessment, goes directly to capital and surplus, would not be taxable, and therefore would lessen the impact to you of raising additional surplus.

The House of Delegates, in a special called meeting on February 9, unanimously elected to raise the necessary funds by assessment.

#### Tort Reform - \$150

The Council on Long-Range Planning and Development at its meeting in October, 1985, approved for submission to the Board of Trustees a major tort reform proposal that called for the formation of a broad-based coalition to be organized in 1986 and culminate in proposed legislation to be considered by the 1987 Legislature.

Events outside the control of the OSMA led to the formation of a coalition much like the plan conceived by the OSMA. However, because of extreme insurance problems experienced by some members of the coalition, the coalition decided to go to the Legislature during this session. The OSMA had to make a decision to join the coalition and participate in the '86 effort or continue with its plans for an '87 program. In January, the Executive Committee decided to join the coalition and called a special meeting of the Board of Trustees and the House of Delegates.

The House of Delegates unanimously voted to levy the \$150 assessment on members and policy fee for non-members, but required that the money be spent only on tort reform.

## PLICO Health

During 1985, a modest rate increase and an increase in the minimum annual deductible to \$300 were instituted. These changes have strengthened the program and put it in a sound financial position. No changes are expected for the program in 1986. During 1986, a study will be made to determine whether a multiple deductible plan will better serve the needs of PLICO policyholders.

As of December 31, 1985, there were 2,428 PLICO Health Policies in force for physicians and 5,245 policies issued to their employees, which represents 19,109 individuals insured under the PLICO Health program. During 1985 a total of 34,936 claims were processed, and a total of \$8,010,892.27 was paid to policyholders. Since PLICO Health's inception, 131,726 claims have been handled with \$30,623,923 in benefits paid to physicians, their families, and employees.

This health program remains the most competitive plan available for physicians and their employees. The reasons are lower overhead and the fact that loss costs have been average for the industry rather than worse for physicians, as accident and health insurance carriers would have had us believe.

This year has seen many challenges and adjustments. It has been a difficult year for your board, as it has required our best efforts to achieve optimum fairness under circumstances, many of which have been beyond our control. As members of the Oklahoma State Medical Association and policyholders of PLICO, we should all be thankful that despite a difficult loss climate, ever larger claims, and problems with reinsurance, we still have a successful program. Although our rates seem high, they are not as onerous as those paid by our peers in other states. Your board pledges to continue to apply its best efforts to keeping our insurance company financially sound and fiscally responsible, while at the same time providing insurance at the lowest possible cost commensurate with the difficult claims we physicians face everywhere.

### Physicians Liability Insurance Company Balance Sheet Year Ended December 31, 1986

<b>Assets</b>	
Cash and Invested Assets	\$29,164,201
Premium Prepaid	(26,974)
Reinsurance Recoverable on Loss Payments	450,187
Interest Receivable	685,324
Receivable from OSMA	650,000
<b>Total Assets</b>	<b>\$30,922,738</b>
<b>Liabilities</b>	
Unearned Premium	\$ 3,605,730
Losses and Loss Adjustment Expenses	23,214,271
Miscellaneous Accounts Payable	53,248
<b>Total Liabilities</b>	<b>26,873,249</b>
<b>Stockholder's Equity</b>	
Common Stock	150,000
Additional Paid-In Capital	5,000,000
Deficit	(1,100,511)
<b>Total Stockholder's Equity</b>	<b>4,049,489</b>
<b>Total Liabilities and Stockholder's Equity</b>	<b>\$30,922,738</b>

### STATEMENT OF OPERATIONS Year Ended December 31, 1985

<b>Revenues</b>	
Earned Premiums	\$20,543,636
Investment Income	3,475,929
Recovery of Bad Debt	(2,796)
<b>Total Revenues</b>	<b>24,016,769</b>
<b>Expenses</b>	
Losses	16,674,795
Loss Adjustment Expenses	3,786,526
Operating Expenses	3,660,488
<b>Total Expenses</b>	<b>24,121,809</b>
Loss	(105,040)
Deficit, Beginning of Year	(995,471)
Deficit, End of Year	(1,100,511)

### Report of C. Alton Brown, MD, President PHYSICIANS LIABILITY INSURANCE COMPANY

To: Oklahoma State Medical Association House of Delegates  
Subject: **Outpatient Psychiatric Care Coverage**

The Oklahoma State Medical Association House of Delegates during your meeting in 1985, requested that PLICO consider expanding coverage for outpatient psychiatric care. I want to assure you that PLICO's objective is to provide the broadest coverage possible in both the Professional Liability line and Accident and Health line of business at the lowest possible premiums.

The PLICO Health Committee considered the OSMA House of Delegates' request to broaden coverage for outpatient psychiatric care. The current coverage is as follows:

"Benefits for outpatient psychiatric care are provided for a maximum of five (5) visits following an inpatient stay for the same or a related condition or diagnosis provided said outpatient visits are provided by the attending physician. Benefits under this provision are subject to a separate \$200 deductible and are limited to a maximum of \$500."

This coverage is as broad as any offered by any competing carrier. Most carriers do not offer outpatient psychiatric coverage at all.

During their deliberations on the request to broaden coverage, the Health Committee had to consider the financial position of the Accident and Health line of business. The Accident and Health line at one point had to borrow money from the Professional Liability line. This has been fully repaid; however, the Accident and Health line is still recovering.

The Health Committee recommended to the PLICO Board of Directors that no changes be made at this time and that the matter be reviewed again in one year. The PLICO Board of Directors ratified the Health Committee's decision.

I want to reiterate that in keeping with PLICO's objective of providing the broadest possible coverage at the lowest possible premiums, PLICO will give full attention to the possibility of broadening coverage for outpatient psychiatric care next year.

## Report of the OKLAHOMANS AGAINST LAWSUIT ABUSE COALITION "RETURN TO REASON" CAMPAIGN

Subject: **Annual Report**

Presented by: Don Blair, OALA Executive Director

Referred to: Reference Committee I

Oklahomans Against Lawsuit Abuse is a broad-based business and professional coalition organized in early January, 1986, for the purpose of securing passage of comprehensive tort reform legislation. It is a non-incorporated committee. OALA offices in the Oklahoma State Medical Association headquarters building in Oklahoma City. Its Executive Director is Don Blair. OALA has its own telephone line, bank account, and post office box.

Originally, OALA was to have a strong general chairman, preferably from the business community, who would be the primary spokesman for the group, and two vice chairmen each from Oklahoma City and Tulsa, representing coalition interests, two of which were to be physicians.

Several prominent businessmen were contacted about assuming the chairmanship, but none could afford to dedicate the time, and some felt inadequate because of the complexities of the subject. Meanwhile the legislative process went into high gear, and the time required for managing the coalition's activities prohibited further recruitment of leadership. The coalition appointed an Executive Committee which implemented the policy decisions of the coalition. It is estimated that OALA represents approximately 400,000 constituents.

A copy of the bill introduced for the coalition is attached. Some modifications were made in the House, but the amended bill passed by the House 89-10 was essentially intact when it arrived at the Senate. The coalition received shoddy treatment in the Senate. The Rules Committee has nine lawyers and nine non-lawyers. Before the bill went to the Committee for a hearing three major sections had been eliminated. With no debate but more amendments, the bill was emasculated and reported do pass from Committee. The Senate's final vote for passage was similar; there was no debate on the merit of the bill when it passed the Senate 41 to 5 with 2 absent.

Incensed by the Senate action, the House amended an already passed bill by inserting some of the provisions of HB 1892 into SB 488. Two weeks ago the Senate rejected SB 488 on a vote of 19-26 and referred the bill to a General Conference Committee.

The coalition has not met since the rejection of SB 488, and the final strategy for action has not been developed. There are members of OALA who would prefer that the bill be killed; others want to secure passage of some measure this legislative session.

Regardless of the outcome, the coalition has been effective in raising public awareness of this issue. They have been moderately successful in raising some money and exceptionally successful in generating demonstrable support at the State Capitol.

There are 22 lawyers in the State Senate, and 19 voted against SB 488, which was essentially a vote against tort reform. Senator Lamb (R) Enid and Senator John McCune (R) Oklahoma City voted for the bill.

Other attachments include a financial statement, a roster of coalition participants, a position paper, House and Senate roll calls, and highlights of HB 1892 and of SB 488.

Respectfully submitted,  
Don Blair  
Executive Director

ENGROSSED HOUSE  
BILL NO. 1892

BY: HOLDEN, MONKS, HOOPER,  
TALLEY, STACY, BROWN,  
FERGUSON, SMITH,  
CUNNINGHAM, WIDENER,  
COTNER, GRIESER, MORRIS,  
MILTON, HEATON,  
LITTLEFIELD, ADAIR,  
CONAGHAN, PITEZEL,  
COZORT, KAMAS, HUNTER,  
OSBORN, McMILLEN, HILL,  
LITTLE and HENSHAW, of the  
HOUSE

and  
ROZELL of the SENATE

AN ACT RELATING TO DAMAGES; AMENDING 12 O.S. 1981, SECTIONS 727, AS LAST AMENDED BY SECTION 1, CHAPTER 257, O.S.L. 1985 and 2404 (12 O.S. SUPP. 1985, SECTION 727) AND 23 O.S. 1981, SECTION 9; ESTABLISHING LIMITATIONS ON DAMAGE AWARDS IN CERTAIN ACTIONS; PROVIDING PROCEDURES FOR PERIODIC PAYMENTS OF DAMAGE AWARDS; AUTHORIZING REDUCTION OF AMOUNT OF DAMAGE AWARD BY AMOUNT OF COLLATERAL SOURCE PAYMENTS RECEIVED AND MAKING EXCEPTIONS; AUTHORIZING REIMBURSEMENT OF COLLATERAL SOURCE BY THE DEFENDANT; LIMITING AMOUNTS OF NONECONOMIC DAMAGE AWARDS; LIMITING AMOUNT OF EXEMPLARY DAMAGE AWARDS IN CERTAIN INSTANCES; EXPANDING GROUNDS FOR AWARD OF EXEMPLARY DAMAGES; PROVIDING FOR STRICT CONSTRUCTION; REQUIRING SEPARATE LISTING OF AMOUNT OF AWARD FOR CERTAIN DAMAGES; DEFINING TERMS; AUTHORIZING AWARD OF COSTS AND ATTORNEYS FEES IN CERTAIN ACTIONS; PROVIDING FOR AMOUNT AND TIME OF COMMENCEMENT OF INTEREST ON SPECIFIED JUDGMENTS; LIMITING INTEREST ON CERTAIN VERDICTS; MODIFYING RATE OF INTEREST FOR CERTAIN AWARDS; MAKING CERTAIN EVIDENCE INADMISSIBLE FOR CERTAIN PURPOSES AND STATING EXCEPTIONS; MODIFYING EXCEPTION; REQUIRING CERTAIN REPORTS FROM CERTAIN INSURERS; PROVIDING FOR PUBLIC ACCESS TO CERTAIN SUMMARIES; STATING CONTENTS OF CERTAIN INSTRUMENTS; PROVIDING FOR RULES AND REGULATIONS; PROVIDING FOR CODIFICATION; REPEALING 12 O.S. 1981, SECTION 1446; PROVIDING FOR SEVERABILITY; AND PROVIDING AN EFFECTIVE DATE.

SECTION 1. NEW LAW A new section of law to be codified in the Oklahoma Statutes as Section 100 of Title 23, unless there is created a duplication in numbering, reads as follows:

In all actions for damages for bodily injury except injury resulting in death, and in all actions for damages for injury to personal rights not arising out of contract including, but not limited to, injury resulting from bodily restraint, personal insult, defamation, invasion of privacy, injury to personal relations, or detriment due to an act or omission of another, if an award of damages includes future damages in excess of Two Hundred Thousand Dollars (\$200,000.00), the future damages in excess of Two Hundred Thousand Dollars (\$200,000.00) shall be paid on a periodic basis as determined by the court. The amounts and times of payments shall be specified in the judgment entered.

In the event of the death of the person entitled to receive the periodic payments, the periodic payments not yet due shall be paid to the estate of the decedent. The court which rendered the original judgment shall make equitable allocations of the periodic payments to those to whom they are entitled.

Interest on the future damages shall be calculated annually on the anniversary date of the judgment on the unpaid balance.

For the purposes of this section, future damages shall mean and include damages for future medical treatment, future care or custody, loss of future earnings, future mental anguish, future impairment to reputation, future harm as a result of loss of right of privacy, or future pain and suffering of the injured person.



**Outgoing OSMA President Elvin M. Amen, MD, presents a gift of appreciation from the association to outgoing Auxiliary President Mary Ann Deen.**

**SECTION 2. NEW LAW** A new section of law to be codified in the Oklahoma Statutes as Section 101 of Title 23, unless there is created a duplication in numbering, reads as follows:

In any action for damages for bodily injury except for injury resulting in death, or in any action for injury to personal rights not arising out of contract including, but not limited to, injury resulting from bodily restraint, personal insult, defamation, invasion of privacy, injury to personal relations, or detriment due to an act or omission of another, in which the liability of the defendant is admitted or adjudicated, a separate hearing shall be held by the court which has determined liability to determine whether or not any of the pecuniary damages sustained or incurred by plaintiff as a result of the injury have been paid or are indemnified from any governmental disability or illness program to which the plaintiff has not made a direct contribution. For purposes of this section, such program shall be the only collateral source considered.

If the court finds that the collateral source provided for in this section has paid or has an obligation to pay any item of damages incurred as a result of the injury, the court shall order the award reduced by an amount equal to the difference between the total of the collateral source payments received, or to be received, and the amount of the award. In the alternative, the Court may order the defendant to reimburse the collateral source for payments made or services rendered if authorized by law.

The provisions of this section shall not be construed to preclude a right of recovery by the collateral source, if applicable, or to create an absolute right of recovery by the collateral source.

**SECTION 3. NEW LAW** A new section of law to be codified in the Oklahoma Statutes as Section 102 of Title 23, unless there is created a duplication in numbering, reads as follows:

In any action for damages for bodily injury except injury resulting in death, or any action for damages for injury to personal rights not arising out of contract including, but not limited to, injury resulting from bodily restraint, personal insult, defamation, invasion of privacy, injury to personal relations, or detriment due to an act or omission of another, in which the plaintiff is awarded noneconomic damages, such damages shall not exceed Two Hundred Fifty Thousand Dollars (\$250,000.00). For purposes of this section, noneconomic damages shall be limited to damages for pain, suffering, inconvenience, loss of consortium, mental anguish, damage to reputation and damages as a result of loss of right of privacy.

**SECTION 4. AMENDATORY** 23 O.S. 1981, Section 9, is amended to read as follows:

Section 9. A. In any action for the breach of an obligation not arising from contract, where the defendant has been guilty of conduct evincing a wanton or reckless disregard for the rights of another, oppression, fraud or malice, actual or presumed, the jury, in addition to the actual damages, may give damages for the sake of example, and by way of punishing the defendant, in an amount not exceeding fifty percent (50%) of the amount of actual damages awarded. Provided, however, if at the conclusion of the evidence and prior to the submission of the case to the jury, the court shall find, on the record and out of the presence of the jury, that there is clear and convincing evidence that the defendant is guilty of conduct evincing a wanton or reckless disregard for the rights of another, oppression, fraud or malice, actual or presumed, then the jury may give damages for the sake of example, and by way of punishing the defendant, and the percentage limitation on such damages set forth in this section shall not apply.

B. The provisions of this section shall be strictly construed.

**SECTION 5. NEW LAW** A new section of law to be codified in the Oklahoma Statutes as Section 61.1 of Title 23, unless there is created a duplication in numbering, reads as follows:

An award of damages for bodily injury except injury resulting in death, or an award of damages for injury to personal rights not arising out of contract, shall identify the portion of the award attributable to future damages, noneconomic damages, and exemplary or punitive damages, as those terms are used in Title 23 of the Oklahoma Statutes.

**SECTION 6. NEW LAW** A new section of law to be codified in the Oklahoma Statutes as Section 103 of Title 23, unless there is created a duplication in numbering, reads as follows:

In any action for damages for bodily injury except injury resulting in death, or in any action for damages to personal rights not arising out of contract the court shall, subsequent to adjudication on the merits and upon motion of the prevailing party, determine whether a claim or defense asserted in the action by a nonprevailing party was asserted in bad faith, was not well grounded in fact, or was unwarranted by existing law or a good faith argument for the extension, modification, or reversal of existing law. Upon so finding, the court shall enter a judgment ordering such non-prevailing party to reimburse the prevailing party for reasonable costs, including attorneys fees, incurred with respect to such claim or defense.

**SECTION 7. AMENDATORY** 12 O.S. 1981, Section 727, as last amended by Section 1, Chapter 257, O.S.L. 1985 (12 O.S. Supp. 1985, Section 727), is amended to read as follows:

Section 727. A. All judgments of courts of record shall bear interest ~~at the rate of fifteen percent (15%) per year~~ a rate prescribed pursuant to subsection B of this section, except judgments against this state and its political subdivisions, including counties, municipalities, school districts, and public trusts of which this state or a political subdivision of this state is a beneficiary, which shall bear interest during the term of judgment ~~at an annual rate of prescribed pursuant to subsection B of this section, but not to exceed ten percent (10%) per year~~ from the date of rendition, provided that:

1. when a rate of interest is specified in a contract, the rate therein shall apply to the judgment debt and be specified in the journal entry of judgment. Said rate shall not exceed the lawful rate for such obligation; or

2. when a verdict for damages by reason of ~~personal~~ bodily injuries or injury to personal rights not arising out of contract including, but not limited to, injury resulting from bodily restraint, personal insult, defamation, invasion of privacy, injury to personal relations, or detriment due to an act or omission of another is accepted by the trial court, the court in rendering judgment shall add interest on said verdict ~~at the rate of fifteen percent (15%) per year~~ a rate prescribed pursuant to subsection B of this section from the date the ~~suit was commenced~~ injury occurred to the date of verdict, provided however that in no event shall interest accrue more than three (3) years prior to the commencement of the action except such verdict against this state and its political subdivisions, including counties, municipalities, school districts, and public trusts of which this state or a political subdivision of this state is a beneficiary, shall bear interest at the rate of prescribed pursuant to subsection B of this section, but not to exceed ten percent (10%) ~~per year~~ from the date the ~~suit was commenced~~ injury occurred to date of verdict, provided that if noneconomic, exemplary, or punitive damages are awarded in an action for bodily injury or injury to personal rights not arising out of contract including, but not limited to, injury resulting from bodily restraint, personal insult, defamation, invasion of privacy, injury to personal relations, or detriment due to an act or omission of another, the interest on said award shall commence as of the date the judgment is entered by the trial court; or

3. when a judgment is rendered establishing the existence of a lien against property and no rate of interest exists, the court shall allow prejudgment interest ~~of fifteen percent (15%) per year~~ at a rate prescribed pursuant to subsection B of this section from the date the lien is filed to the date of verdict.

B. For purposes of this section, interest shall be at an annual rate equal to the average United States Treasury Bill rate of the preceding calendar year as certified to the Administrative Director of the Courts by the State Treasurer on the first regular business day in January of each year, plus one percent (1%).

**SECTION 8. AMENDATORY** 12 O.S. 1981, Section 2404, is amended to read as follows:

Section 2404. A. Evidence of a person's character or a trait of his character is not admissible for the purpose of proving that he acted in conformity therewith on a particular occasion, except:

1. Evidence of a pertinent trait of his character offered by an accused or by the prosecution to rebut the same. Such character evidence shall be limited to the ten (10) years immediately preceding the incident for which the action was commenced;

2. Evidence of a pertinent trait of character of the victim of the crime offered by an accused, or by the prosecution to rebut the same, or evidence of a character trait of peacefulness of the victim offered by the prosecution in a homicide case to rebut evidence that the victim was the first aggressor; or

3. Evidence of the character of a witness, as provided in Section 607, 608 and 609 of this Code.

B. Evidence of other crimes or acts is not admissible to prove the character of a person in order to show that he acted in conformity therewith. It may, however, be admissible for other purposes, such as proof of motive, opportunity, intent, preparation, plan, knowledge, identity or absence of mistake or accident.

SECTION 9. A. All insurance companies licensed to sell casualty insurance in Oklahoma shall file an annual report with the State Insurance Commissioner in detail:

1. Gross premiums received from all Oklahoma policyholders;
2. Identify each claim paid, to whom paid, the amount and date;
3. Identify specific amount for each claim as reserve for possible future payments incurred;
4. Interest earned, yield, from/on all reserve funds for Oklahoma insureds accounts and whether earnings were credited back to premiums due or were taken into profits;
5. Detail of the cost/paid out for all legal expense: to whom; for what; amount;
6. The amount charged by the licensed casualty insurance company for administration, including gross profits;
7. The amount of all money received by subrogation claims.

B. A summary of the above annual report shall be made available free of cost to each policyholder and agent when the bill for renewal is mailed. Provided further that calendar year filings with the State Insurance Commissioner and the summary notice mailed to each policyholder shall state how the premium or fee was determined:

1. By area of this state;
2. By all of this state;
3. Whether lumped nationally or regionally;
4. Any other way rates were determined.

All such required filings shall be public records.

C. The State Insurance Commissioner is hereby authorized to issue rules to implement the Legislative intent as herein is expressed.

SECTION 10. REPEALER 12 O.S. 1981, Section 1446, is hereby repealed

SECTION 11. The provisions of this act are severable and if any part or provision shall be held void the decision of the court so holding shall not affect or impair any of the remaining parts or provisions of this act.

SECTION 12. This act shall become effective November 1, 1986.

Passed the House of Representatives the 26th day of February, 1986.

\_\_\_\_\_  
Speaker of the House of Representatives

Passed the Senate the \_\_\_\_\_ day of \_\_\_\_\_, 1986.

\_\_\_\_\_  
President of the Senate



"Laser Surgery in Gynecology" is the topic as David A. Kallenberger, MD, opens the OB/GYN section of the Scientific Program on Thursday. Dr Kallenberger is a clinical assistant professor at Tulsa Medical College.

#### Oklahomans Against Lawsuit Abuse

##### Contributions:

Don Blair	\$ 25.00
Oklahoma Hospital Association	1,000.00
Oklahoma Nurses Association	300.00
Oklahoma State Chamber of Commerce	2,000.00
Oklahoma Automobile Dealers	2,000.00
Blue Cross/Blue Shield	1,000.00
Presbyterian Hospital	5,000.00
Assoc. of Oklahoma Gen. Contractors	500.00
Bogert Oil Co.	500.00
Downing Wellhead Equipment	500.00
Dr. William Grubb	50.00
Oklahoma State Medical Association	20,000.00
Oklahoma Press Association	2,500.00
Tierco Group	500.00
Musket Corporation	1,000.00
The Charles Machine Works, Inc.	500.00
Oklahoma Gas & Electric	1,000.00
Oklahoma Society of Prof. Engineers	200.00
Local Federal	1,000.00
OK Society of Cert. Public Accountants	2,500.00
OK State Nursing Home Association	1,000.00
Oklahoma Dental Association	1,000.00
Halliburton Services	1,000.00
United Community Corporation	1,500.00
Continental Federal	250.00
Oklahoma Bankers Association	500.00
Macklanburg-Duncan	1,000.00
The Denman Company	50.00
Retail Lumber & Bldg. Material Dealers	1,000.00
Oklahoma LP-Gas Association	1,000.00
OK Association of Nurse Anesthetists	500.00
Kenneth Beyers	10.00
American First Corporation	500.00
Western OK Charter N.E.C.A.	500.00
Dolese Brothers Company	5,000.00
Carrol Carr	25.00
Consulting Engineers Council of OK	1,000.00
Alliance of American Insurers	750.00
OK Society of Cert. Public Accountants	2,500.00
Wm. E. Davis & Sons, Inc.	500.00
OK Osteopathic Political Action Comm.	1,000.00
Flint Industries	1,000.00
Fred Jones Foundation	2,500.00
OK Assoc. of Defense Counsel	1,000.00
Unit Drilling and Exploration Co.	1,000.00
Oklahoma Malt Beverage Association	350.00
Independent Insurance Agents of OK	250.00
Total Contributions	\$68,760.00
Interest on Savings Account	233.18
	<u>\$68,993.18</u>

##### Expenditures:

Bank Service Charge	\$ 5.00
Duchess Bartmess, Attorney at Law	1,465.00
S. W. Bell Telephone Co.	162.37
Richard Hess & Associates	1,111.42
At Your Service, Inc.	20,000.00
Journal Record Publishing	485.08
S. W. Bell Telephone Co.	36.78
Don Blair	175.00
Oklahoma Transportation Co.	622.50
Oklahoma Transportation Co.	(112.50)
Richard Hess & Associates	531.17
Oklahoma Press Service, Inc.	29,710.38
Oklahoma Press Service, Inc.	733.00
Oklahoma Press Service, Inc.	189.10
Speed Press	113.31
S. W. Bell Telephone Co.	44.87
Bank Check Charge	49.12
Bank Service Charge	28.00
S. W. Bell Telephone Co.	44.87
Total Expenditures	<u>\$55,394.47</u>
Total Contributions	\$68,993.18
Total Expenditures	(55,394.47)
Total Cash in Bank	<u>\$13,598.71</u>

## Participating Organizations

Alliance of American Insurers  
 American First Corporation  
 American Institute of Architects  
 Associated Motor Carriers  
 Association of Oklahoma General Contractors  
 AT&T Government Relations  
 Bogert Oil Company  
 The Charles Machine Works, Inc.  
 Consulting Engineers Council  
 Continental Federal Savings and Loan  
 The Denman Company  
 The Dolese Brothers Company  
 Domestic Insurance Association  
 Dowling Wellhead Equipment Company  
 Flint Industries, Inc.  
 Fred Jones Foundation  
 Halliburton Services  
 Hospital Corporation of America  
 Independent Insurance Agents of Oklahoma  
 KWTV 9  
 Local Federal Savings and Loan  
 Love's Country Stores  
 Macklanburg Duncan  
 Manufactured Housing Association of Oklahoma  
 Metropolitan Tulsa Chamber of Commerce  
 Motor Vehicle Manufacturers Association  
 National Electrical Contractors Association  
 National Federation of Independent Business  
 Oklahoma Academy of Family Physicians  
 Oklahoma Association of Broadcasters  
 Oklahoma Association of Defense Counsel  
 Oklahoma Association of Electric Cooperatives  
 Oklahoma Association of Realtors  
 Oklahoma Automobile Dealers Association  
 Oklahoma Bankers Association  
 Oklahoma Cable Television Association  
 Oklahoma City Chamber of Commerce  
 Oklahoma City Motor Car Dealers Association  
 Oklahoma Dental Association  
 Oklahoma Farm Bureau  
 Oklahoma Farmers Union  
 Oklahoma Gas and Electric Company  
 Oklahoma Grain and Feed Association  
 Oklahoma Health Systems Agency  
 Oklahoma Hospital Association  
 Oklahoma Hotel and Motel Association  
 Oklahoma Independent Petroleum Association  
 Oklahoma League of Savings Institutions  
 Oklahoma LP Gas Association  
 Oklahoma Lumbermen's Association  
 Oklahoma Malt Beverage Association  
 Oklahoma Natural Gas Company  
 Oklahoma Nurses' Association  
 Oklahoma Oil Marketers Association  
 Oklahoma Osteopathic Association  
 Oklahoma Pharmaceutical Association  
 Oklahoma Press Association  
 Oklahoma Public Health Association  
 Oklahoma Restaurant Association  
 Oklahoma Retail Grocers Association  
 Oklahoma Retail Merchants Association  
 Oklahoma Society of Certified Public Accountants  
 Oklahoma Society of Professional Engineers  
 Oklahoma State Chamber of Commerce and Industry  
 Oklahoma State Home Builders Association  
 Oklahoma State Medical Association  
 Oklahoma State Nursing Home Association  
 Southwestern Insurance Information Service  
 State Farm Insurance Company  
 The Tierco Group, Inc.  
 Tribune-Swab-Fox Company, Inc.  
 Unit Drilling and Exploration Company  
 United Community Corporation  
 William E. Davis & Sons, Inc.

(Position Paper)

## TORT REFORM IS NEEDED — NOW!

### Who Says There Is a Crisis in Our Tort System?

- The Judicial, Legislative and Executive branches of our Federal Government have identified the issues as a major national problem.
- Legislators of more than 20 states are examining tort reform . . . significant corrective legislation has already been passed in a number of states.
- The "American Tort Reform Association" has declared that a national crisis exists . . . ATRA represents 960,000 businesses, professionals and public entities which employ 19,000,000 Americans.
- "Oklahomans Against Lawsuit Abuse," which represents 300,000 state businessmen, professionals, farmers and institutions, has been established as an ongoing organization to correct abusive civil laws.
- Insurers in America and abroad have identified our nation as the most litigious society in the world.
- The vast majority of the American people believe that our tort system is out of control.

### Who Denies That Any Civil Justice Problem Exists?

- The damage-suit lawyers — known as the 60,000-member American Trial Lawyers Association — who are spending \$25 million this year to block corrective tort reform efforts and thereby preserve a "status quo" which generates \$55 billion a year in lawyer income . . . this small but prosperous group has also accumulated \$850 thousand for congressional candidate support.

### How Big Is the Problem?

- 16.6 million lawsuits were filed in America last year . . . 1 out of 13 citizens were involved . . . \$60 billion of our Gross National Product is being consumed through "litigation pollution," a phrase coined by the Dean of the Stanford Law School.
- The number of civil lawsuits filed in Oklahoma is up 59% over the last decade . . . nationally, tort claims are compounding by an annual growth rate of 15 to 20%.
- Nearly one-half of all the premiums required to insure all the risks in the world are being collected to cover the claims exposure in the United States.
- Insurance premiums in America now consume 11.1% of all disposable income — the fourth greatest expense after food, housing and Federal Income Tax!
- The US has 6% of the world's population and 66% of the world's lawyers; the number of lawyers is multiplying at six times the rate of our national population; 13% of them advertise for damage suits; 200,000 more lawyers will be produced within the next four years . . . how will they make their livings?
- Only 37 cents of the damage-suit dollar went to 30,000 asbestosis victims — the rest went to lawyers.
- Over 400 awards of a million dollars or more occurred in the US in 1984; there were about 500 in 1985, and even more are expected in 1986.
- The number of product liability suits jumped 600% over a 10-year period.
- 367 verdicts of a million dollars or more have been registered against physicians over the years.
- The average product liability claim costs more than \$1 million . . . the average medical malpractice settlement is \$330,000.
- Premiums for commercial liability coverage have generally increased within the range of 50% to 800% — but the costs of some high-risk policies are up tenfold in 1986, and other risky but essential coverages are not available at all.
- The total premium necessary to insure Oklahoma's 4,000 Medical Doctors increased from an aggregate of \$6 million in 1980 to \$22 million in 1985 — 366% more money is needed to bankroll the risk.
- State Doctors of Osteopathy have experienced the business failure of their insurer — some 300 of the physicians who care for 500,000 Oklahomans have found no replacement coverage.
- In short, our state's businessmen, physicians, dentists, hospitals, cities, architects, engineers, CPAs, farmers, propane dealers and ad infinitum have been placed in economic straight-jackets by the plaintiffs bar, by an out-of-control tort system and by overly-generous juries.
- The lawsuit binge is destroying the enterprise, the enthusiasm and the energy of our state's most productive resources . . . businesses are failing, good products are being taken from the marketplace, invention is stifled, jobs are lost; we are experiencing an internal destructive force unlike any other nation on earth.
- The principal executive of Lloyd's of London has declared America to be off limits and has named tort reform as a requirement for future consideration.

### Who Pays the Tab?

- Every citizen — as insurance premiums increase the overhead expenses of businessmen, manufacturers and professionals, the prices of their products and services rise correspondingly.
- Examples: 20% of the cost of a ladder is attributable to insurance . . . Squaw Valley ski lift tickets are up \$3 a day for the same reason . . . child care centers' daily costs are up 30% for the same reason . . . business failures cost jobs, and more and more failures are due to lawsuit mania.

### What Do the People Think about America's Lawsuit Binge?

- The vast majority of our citizens do not like what's going on at the courthouse . . . and they are the "Court of Public Opinion."
- If 4% of the population file civil damage suits each year, the other 96% are either not involved or are defendants.
- 55% of Americans surveyed in a 1985 national poll conducted by Cambridge Reports attributed the increase in civil lawsuits to (1) greed, (2) overzealous lawyers, (3) the size of verdicts and settlements, (4) lawsuit publicity and (5) "people too quick to sue."

**Will Tort Reform Be Fair?**

- The "Return to Reason" campaign seeks to restore even-handed justice . . . we are in favor of generous jury awards for people who have been injured through the fault of others, but we are opposed to outrageously high verdicts which grossly overcompensate an injury.
- HB 1892 places reasonable limits on subjective damages like "pain and suffering" and "punitive" (except in death cases); there are no limitations on actual damages, and the trial judge may lift the restriction on punitive damages in extreme cases involving the reckless disregard for the rights of others.
- Nothing in HB 1892 abridges the right of an injured person to have free access to the courts or to receive fair and generous compensation for an injury.

**Is Tort Reform the Product of an Insurance Industry Scam?**

- No. Those few damage-suit lawyers and consumer advocates who say so are insulting the intelligence of a legion of government and private authorities who recognize an unprecedented abuse of our court system which is exceedingly destructive to our economy and to the moral fibre of our people.
- From 1967 to 1985 the insurance industry lost \$81.3 billion in operations, but gained \$119.8 billion in investment income, resulting in a \$38.5 billion gain — but this 4% return on net worth over an 18-year period was less than the Fortune 500 all-industry average for 13 of these years.
- In 1984, when an industry-wide 3.8 billion operational deficit was reported, the insurance companies' return on net worth was 11 points less than the Fortune 500.
- A steady decline in the insurance industry's surplus is restricting its capacity to accept risk.
- The respected A.M. Best Company rates the financial strength of insurers . . . from 1982 to 1983, 30 insurance companies were upgraded to "excellent" while 78 fell out of this top rating classification . . . in 1984, the ratings of 150 companies slipped, and in 1985 there were 331 companies whose ratings dropped.
- According to Mavis A. Walters, Senior Vice President of the prestigious Insurance Services Office (a New York rating, statistical and actuarial service which is **not** an insurance trade association), the insurance industry "has been a victim of fundamental changes in the civil justice system." He cites such problems as: (1) court interpretations of prior insurance contracts which expand coverage; (2) insurers' concerns about unanticipated past liability; (3) the magnitude of potential liability, past and future; (4) a civil justice system that continues to create new theories of liability and to expand older theories; and (5) defense costs which have grown from 15% of damages in the 1950's to 34% in 1983 and which are now approaching 50% of damages.
- The damage-suit lawyers claim that some insurance companies' stocks are rising in value on the stock exchange is true . . . many stock analysts are predicting that a depressed industry is on the road to recovery **because premiums are on the rise and particularly hostile coverages are being abandoned.**
- The expansive, liberalized tort system is the principal source of the insurance crisis . . . while insurers' investment income has risen continuously since 1979 by an average annual rate of \$1.7 billion, the average annual underwriting loss was \$3 billion!

**Should an "Insurance Study" Precede Tort Reform?**

- No! Controls should be placed on a runaway civil justice system in 1986 . . . Oklahoma's beleaguered economy cannot wait for a protracted study to be completed.
- The insurance industry can be investigated later, if necessary, or creditable studies recently conducted by other State Legislatures could be efficiently utilized.

**If a Tort Reform Law Is Passed, Will Insurance Companies Respond?**

- Yes, in the course of time, tort reform will improve loss experience and will restore the **predictability** of risk exposure.
- The results will not be immediate, because it may take years to see the moderation of loss experience; additionally, the insurance industry will require time to become financially rehabilitated — **BUT TORT REFORM WILL CREATE THE FAIR LEGAL ENVIRONMENT NECESSARY FOR PREMIUM REDUCTIONS IN THE FUTURE. DELAY CAN BE RUINOUS. THE SICKNESS IN OUR LAWS AND IN OUR SOCIETY MUST BE ADDRESSED — NOW!**

**OKLAHOMA HOUSE VOTE**

5/ Vote for HB 1892

Bill Number HB 1892

Date 02/26/86

Vote Type Third Reading, Vote on Passage as Amended

House of Vote House

Yes Abbott, Adair, Anderson, Barker, Bastin, Benson, Blodgett, Boeckman, Brewster, Brown (Bob), Clark, Collins, Conaghan, Converse, Cotner, Cox, Cozort, Craighead, Cunningham, Davis (Frank), Davis (Guy), Duckett, Duke, Easley, Fair, Ferguson, Formby, George, Gish, Glover, Gordon, Graves, Grieser, Hale, Hamilton (James), Haney, Harbin, Harris (Robert), Heaton, Henry, Henshaw, Hill, Hobson, Holden, Hooper, Hunter, Kamas, Kelly, Kincheloe, Koppel, Larason, Leftwich, Lewis, Little, Littlefield, Manar, McDonald, McKenna, McMillen, Mentzer, Milton, Mitchell, Monks, Morgan, Morris, Murphy, Newby, Osborne, Pitezel, Reimer, Rieger, Roberts (Larry), Sanders, Schroeder, Sherrer, Shurden, Smith (Bill), Stacy, Talley, Thompson, Vanatta, Vaughn, Virtue, Whorton, Widener, Williams (Freddie), Williams (Penny), Williamson, Willis

No Combs (Gene), Hamilton (Rebecca), Harris (Ken), Johnson (Glen), Lawter, Logan, McCorkell, Riggs, Ross, Stottlemeyer

Excused Holt, Patrick

Vote Totals Aye: 89 Nay: 10 Ex: 2

**OKLAHOMA SENATE VOTE**

SB 488 Table Motion

19 Yeas 26 Nays 3 Exc

4-23-86			
Boatner	Y	Luton	N
Branch	N	McCune	Y
Brown	N	McIntyre	X
Cain	N	Miller	N
Capps	Y	O'Connor	Y
Cate	N	Pierce	X
Choate	Y	Porter	N
Cole	Y	Randle	N
Combs	N	Rhodes	N
Cullison	N	Roberts	N
Dahl	Y	Rozell	Y
Dawson	N	Sadler	Y
Dennis	N	Schuelein	Y
Floyd	Y	Shedrick	N
Ford	Y	Smith	N
Giles	X	Stipe	N
Green	N	Taliaferro	Y
Hopkins	N	Taylor	N
Howell	N	Terrill	N
Johnson	Y	Watson	Y
Keller	N	Winn	Y
Lamb	Y	Wright	N
Landis	Y	York	N
Leonard	N	Young	Y



**Dr Elvin M. Amen, OSMa president 1985-86, and his wife, Lucile, enjoy themselves at the Friday night Inaugural Ball.**

## HIGHLIGHTS OF HOUSE BILL 1892

### What HB 1892 Would Change:

1. **Non-Economic Damages**, such as "pain and suffering" and "mental anguish," would be limited to a maximum of \$250,000 but would be **unlimited in death cases**. Non-economic damages are paid in addition to actual damages.
2. **Punitive Damages** for "wanton or reckless conduct, oppression, fraud or malice" would be limited to 50% of actual damages except in death cases. (The judge could remove the limitation in extreme cases. Punitive damages are paid in addition to actual damages.)
3. **Future Damages** above \$200,000 would be paid in installments to guaranty the injured party's financial security and to permit the use of annuities to reduce the cost of providing the promised total benefit. The installments are in addition to \$200,000 of lump-sum future damages and past actual damages.
4. **Damage-Suit Awards** would be reduced by the amounts of injury-related insurance benefits received or owed, thereby avoiding unfair double recovery. (The House limited this offset to governmental disability or illness programs.)
5. **Attorneys Fees and Other Reasonable Costs** incurred by the prevailing party may be imposed by the court on the losing party if it is found that a claim or defense was asserted in bad faith, or was not based on fact, or was unwarranted by existing law or by a good-faith argument for the extension, modification or reversal of existing law.
6. **Pre-Judgment and Post-Judgment Interest** would be reduced from the present 15% to the floating US Treasury Bill rate plus 1%. Only post-judgment interest would accrue on punitive and non-economic damages (while on appeal); pre-judgment interest would be confined to actual damages.
7. **Increased insurance industry accountability** would be required.

### What HB 1892 Would Not Change:

1. Full Access to the Court for Everyone
1. Unlimited Awards for Actual Damages

### HB 1892 is Needed Now, Because:

1. All State and National Studies Identify Tort Reform as an Emergency Need — Now!
2. The Insurance Industry is not the Principal Problem!
3. Over-zealous Lawyers, the Escalating Number of Damage Suits, the Outrageous Jury Awards and the Unpredictability of Risk Unique to America are the Principal Causes of Excessive Insurance Premiums and Unavailable Coverages.

#### Analysis of Engrossed SB 488

Including House Amendments as SB 488 Awaits Senate Concurrence  
(Prepared for Oklahoma Press Association  
by Ben Blackstock 16 April 1986)

**Sections 1-10:** Creates the "Market Assistance Association Act" to require insurers to provide coverage and share cost experiences for persons or firms refused any form of liability coverage; provides Oklahoma licensed insurers may voluntarily form such an association within 90 days of effective date of SB 488; if not done Insurance Commissioner is directed to form same. (Concept also in SB 488, SB 561)

**Section 11:** Punitive, exemplary damage awards shall not exceed 50% of actual damages unless the judge removes such 50% limit upon "clear and convincing evidence" of wanton or reckless disregard for the right of another. However, interest on punitive awards shall commence as of the date of judgment. Senate substitute was "preponderance of evidence." (Concept also in HB 1892, SB 536)

**Section 12:** Taken word for word from Article 7, Section 15 of the Oklahoma Constitution it provides the judge may direct awards be identified by amount and kind rather than lumping all classes of actual damages. (Concept also in HB 1892, SB 536)

**Section 13:** Legal expense may be awarded the prevailing party not to exceed \$10,000 if court finds either the plaintiff or defendant presented case without merit. (Concept also in HB 1892, SB 536, SB 561).

**Section 14:** Interest rate shall be average T-bill plus 4 percentage points (is now 15% for business firms; 10% for governmental entities). Interest provision passed the House in HB 1892 as T-bill plus 1%. Senate Rules raised it to T-bill plus 4%. The Senate-passed language is retained. (Concept also in HB 1892, HB 536)

Interest on actual damage awards is to be calculated from the date the case is filed, which is present law. However, interest on punitive damages is to be figured from the date the judgment is entered by the trial court; also present law.

**Sections 15-22:** Shall be known as "Unfair Claim Settlement Practices Act" requiring insurers to adopt and follow reasonable standards for prompt handling and determination of all claims; instructs Insurance Commissioner to devise and order periodic reports; provides enforcement. (Concept also in SB 561)

**Sections 23-24:** Directs Insurance Commissioner to issue rules requiring insurers to annually report income, expenses, reserves and other data which shall be a public record. (Concept also in HB 1892, SB 536, SB 561).

**Section 25:** Creates a "Select Interim Committee on Tort Claims" consisting of 18 members; 5 Senators; 5 House members; 8 citizens, 4 of whom shall be appointed by the President Pro Tempore of the Senate and 4 by the Speaker of the House. Subpoena powers granted. Travel expenses to be reimbursed. Findings and recommendations must be made to the President Pro Tempore and Speaker not later than January 1, 1987. (Concepts also in HB 1892, SB 536, SB 561).

**Section 26:** Repeals old law.

**Section 27:** Severability clause.

**Section 28:** Effective date for SB 488 is November 1, 1986 except for the interim study which **Section 29** provides as emergency.

\*\*\*SB 488 as amended and passed by House 86-4 does not include these parts as HB 1892 passed the House:

- 1) reduce award by amount of collateral sources
- 2) court schedule periodic payments of awards over \$200,000
- 3) noneconomic damages not to exceed \$250,000

## Report of the OKLAHOMA STATE MEDICAL ASSOCIATION AUXILIARY

### Subject: Annual Report

Presented by: Mrs Mary Ann Deen, President

Referred to: Reference Committee I

The Oklahoma State Medical Association Auxiliary has again had a good year. We have made friends and have maintained our membership of around 1,361 female and male spouses of physicians, who belong to fifteen local auxiliaries, as well as being Members-At-Large. Our state board is made up of state officers, committee chairmen, county presidents, and county presidents-elect. This year the president and president-elect traveled 13,499 miles, collectively, in the State of Oklahoma. Sixteen airline tickets were purchased by Oklahoma auxiliaries to travel to Chicago for attendance at various national meetings.

Besides having numerous fun projects such as barbecues, luncheons, visits to gourmet shops, Neiman-Marcus in Dallas, and a trip to antique shops, our state auxiliaries have raised to date \$29,560.06 for AMA-ERF, our only national philanthropy. Oklahoma's contribution will help the AMA Auxiliary to reach its goal of \$2 million for the year 1985-86!

Auxiliaries have lobbied this year both on state issues as well as local ones. Over one hundred members attended our Day at the Legislature, along with OSMA staff and physicians. Seven local auxiliaries heard programs on tort reform with OSMA speakers or legislators themselves speaking. The auxiliary is developing a comprehensive pilot program to be used in 1986-87 for a Legislative Action Committee. We are well aware of the legislative issues that we face, and one tangible result is membership in the PAC. OSMAA membership in OMPAC-AMPAC increased by 770% — from two to 155!

Improvement of our image, as well as that of our physician spouses, was a focus this year, and the auxiliary scored high:

More than 5,000 school students were given programs on healthy lifestyles, viewed puppet shows on drug abuse, and learned babysitting techniques, prenatal-postnatal care, and other subjects by auxiliaries.

Over \$80,000 in checks were written to over fifteen agencies or organizations, including a \$55,000 grant to upgrade an ambulance service.

Lifesize dolls to be used for pre-surgical patients in pediatric wards, books for pediatric departments, steps to assist handicapped in entering swimming pools, trees planted in doctors' honor, and one hundred stockings for children at Christmas were some of the items donated by local auxiliaries.

The state auxiliary sponsored a Media Day, at which members of the media were entertained by local auxiliaries. The returns were great. Projects had excellent coverage, such as live radio show at a health fair, newspaper judges of a Doctors' Day project, Call the Doctor shows, as well as ads placed on organ donation. Over \$1,500 in public service announcements were placed on radio and TV stations concerning immunizations and Medi-File.

At least fifteen scholarships and awards were given, totaling more than \$2,000.

More than 2,000 hours were donated in health projects such as health fairs, parties for senior citizens, meals on wheels, parties for hospital staffs, as well as service to rape and child abuse centers, and staffing bloodmobiles.

Altogether more than \$125,000 has been obtained and distributed by auxiliaries in the State of Oklahoma.

How did we do it? By having dedicated spouses who raised funds at rummage sales, auctions, luncheons and fashion shows, tennis tournaments, basketball games, as well as others. We also did it with the help and support of the OSMA:

Doctor Amen, Doctor Dunitz, and the Board of Trustees  
Dave Bickham and the entire staff

By being included in the OSMA budget this year

By having your financial support as well as advice in distributing over 130,000 Medi-File cards to senior citizens, and

By being included in your programs, as well as having the expertise of several of your speakers — Dr Perry Lam-bird, Dr Darrel Smith, Doctor Amen, David Bickham, Ed Kelsay, Mike Sulzycki, Otie Ann Carr, Robert Baker — in our own programs.

Thank you!

Respectfully submitted,  
Mary Ann Deen  
OSMAA President

## Reference Committee II

# REPORTS TO THE HOUSE OF DELEGATES

### Report of REFERENCE COMMITTEE II

Presented by: Lee N. Newcomer, MD, Chairman

Mr Speaker and Members of the House of Delegates:

Reference Committee II gave careful consideration to the several items referred to it and submits the following report:

#### (1) *Report of the President*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the President be adopted.

Your Reference Committee would like to convey its most sincere gratitude and appreciation to Elvin M. Amen, MD, for his excellent leadership throughout the past year.

The Reference Committee feels Doctor Amen's program of active involvement by OSMA members was an unqualified success. We thank him for being available and for devoting countless hours to our Association.

#### (2) *Report of the Council on Professional and Public Relations*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Professional and Public Relations be adopted.

Your Reference Committee would like to commend M. Joe Crosthwait, MD, and Mike Sulzycki, OSMA Associate Director, for the outstanding production of the film "Preserving Tradition, Embracing Change."

We recommend that the Council consider additional films in the future at the discretion of the Board of Trustees.

#### (3) *Progress Report, Oklahoma State Medical Association Medical Student Program*

Recommendation:

Mr Speaker, your Reference Committee recommends that the Progress Report of the Oklahoma State Medical Association Student Program be filed for information.

The Reference Committee would like to commend Wilson D. Steen, PhD, for the work he has done to organize the medical student section of the OSMA.



Elvin M. Amen, MD, ending his year as OSMA president, offers some parting words at the Inaugural Ball.

- (4) *Report of the Council on Public and Mental Health*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that the Report of the Council on Public and Mental Health be adopted.  
Your Reference Committee would like to express its gratitude for the manner in which the Council carried out its assigned duties.
- (5) *Report of the Council on Medical Education*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that the Report of the Council on Medical Education be adopted.  
Your Reference Committee would like to express its appreciation to the Council for effectively carrying out its assigned duties.
- (6) *Report of the Council on Medical Services*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that the Report of the Council on Medical Services be adopted.  
Your Reference Committee would like to extend special commendation to John A. Blaschke, MD, Council Chairman, for his exceptional service.

- (7) *Report of the Section on Hospital Medical Staffs*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that the Report of the Section on Hospital Medical Staffs be adopted.  
The Reference Committee noted the formation of a new Hospital Medical Staff Section, election of officers, and a new agenda.
- (8) *Report of the Oklahoma Foundation for Peer Review*  
Mr Speaker, your Reference Committee is aware that the President-Elect of the OFPR Board gave a report to the OSMA Board of Trustees at its annual meeting Wednesday. There was no written report for your Reference Committee to consider. House of Delegates action on the OFPR Report will be considered as a part of the Board of Trustees Supplemental Report.
- (9) *Report of the JOURNAL of the Oklahoma State Medical Association*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that the Report of the JOURNAL of the Oklahoma State Medical Association be adopted.  
The Reference Committee noted the appointment of Donald Brawner, MD, as a new member of the JOURNAL Editorial Board, replacing Robert Tompkins, MD.  
The Reference Committee would like to express its appreciation to Doctor Tompkins for his many years of dedicated service on the Editorial Board.
- (10) *Resolution 1 — National Catastrophic Medical Insurance*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that Resolution 1 be adopted as amended.  
The concept of medical catastrophic insurance has already been introduced before the AMA; therefore, lines 18-20 on page 1 should be deleted.
- (11) *Resolution 3 — Beef and Coronary Heart Disease*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that Resolution 3 be adopted.
- (12) *Resolution 4 — Medical School Admissions Reduction*  
Recommendation:  
Mr Speaker, your Reference Committee recommends that Resolution 4 be adopted as amended.  
There was considerable debate over this resolution. There was a general consensus of agreement with the philosophy of the resolution.  
The Reference Committee recommends the deletion of lines 6 and 7; the last word on line 16; and lines 17 and 18.  
*Resolved*, That the Oklahoma State Medical Association recommend that the Oklahoma State Legislature amend present statutes to provide for a 15% reduction in enrollment of medical and osteopathic students on a pro rata basis; and be it further  
*Resolved*, That the OSMA recommend to the Oklahoma State Legislature and to the University of Oklahoma Health Sciences Center that an immediate suspension be placed on all admissions to the Physicians' Assistant Training Program; and be it further

Resolved, That the OSMA recommend that the Oklahoma State Legislature introduce legislation repealing the Physicians' Assistant Training Act.

(13) *Resolution 6 — Foreign Medical Graduates in Residency Programs*

Recommendations:

Mr Speaker, your Reference Committee recommends that the following substitute resolution be adopted in lieu of Resolution 6.

Resolved, That the Oklahoma State Medical Association and the American Medical Association urge residency programs in Oklahoma to employ only graduates of LCME approved medical schools or graduates of foreign medical schools whose training is subsidized by their respective countries and who are required to return to those countries upon completion of their residency training; and be it further

Resolved, That the United States Congress be urged to repeal the Desirable Alien Act; and be it further

Resolved, That the Oklahoma State Board of Medical Examiners be apprised of this resolution.

There was vigorous debate regarding the placement of FMGs in residency programs.

(14) *Resolution 7 — Family Physicians' Second Opinions*  
Recommendation:

Mr Speaker, your Reference Committee recommends the following substitute resolution be adopted in lieu of Resolution 7.

Resolved, That the OSMA encourage third-party payors and other interested parties to recognize the ability of Primary Care Physicians to render second opinions regarding the necessity of primary care diagnostic or therapeutic procedures.

(15) *Resolution 9 — Non-Smokers Inhalation*  
Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 9 be adopted.

(16) *Resolution 10 — Primary Care Physicians*  
Recommendation:

Mr Speaker, your Reference Committee recommends adoption of the following substitute resolution in lieu of Resolution 10:

Resolved, That the Oklahoma State Medical Association support changes in the medical education system that will create doctors that will be able to locate in areas of Oklahoma that need physicians including but not limited to:

1. A primary-care oriented curriculum from the first day of medical school;
2. More medical education programs (student and resident clerkships) in the less populated areas of the state;
3. Consideration of the resident spending at least part of the third year of residency in a location suitable for his or her eventual practice location.
4. Encourage locum tenens in rural Oklahoma practices.

(17) *Resolution 12 — Cutbacks in Funding in Prenatal Care*  
Recommendation:

Mr Speaker, your Reference Committee voted not to adopt Resolution 12.

Your Reference Committee agreed with this resolution, but felt that it was redundant with Resolution 19 — Governor's Task Force of Perinatal Care.

(18) *Resolution 17 — Smokeless Tobacco Education and Prohibiting Use of All Tobacco Products in Schools*  
Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 17 be adopted.

(19) *Resolution 19 — Governor's Task Force on Perinatal Care*  
Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 19 be adopted.

(20) *Resolution 22 — Medical Health Officers*  
Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 22 be adopted.

(21) *Resolution 23 — Crisis Intervention Center*  
Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 23 be adopted.

Mr Speaker, this concludes the Report of Reference Committee II. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report.

Respectfully submitted,

Lee N. Newcomer, MD, Chairman, Tulsa  
Stephen E. Acker, MD, Oklahoma City  
Billy Dale Dotter, MD, Okeene  
F. Daniel Duffy, MD, Tulsa  
Ambrosio Solano, Jr., MD, Owasso  
Roland A. Walters, MD, Oklahoma City  
Mike Sulzycki, Staff  
Susan Meeks, Staff

## Report of the COUNCIL ON PROFESSIONAL AND PUBLIC RELATIONS

Subject: **Annual Report**

Presented by: M. Joe Crosthwait, MD, Chairman

Referred to: Reference Committee II

### Introduction

The Council on Professional and Public Relations is responsible for the internal and external communications program of the Oklahoma State Medical Association. The overall goals of the Council are: 1) to improve and maintain understanding among Oklahoma physicians, their patients, and the public; and 2) to keep members informed about programs, policies, and activities undertaken by the Association affecting the practice of medicine in Oklahoma.



At Wednesday night's dinner for the Board of Trustees and their guests, OSMA Executive Director David Bickham sums up the past year's accomplishments and the new year's challenges.

### Review of Activities

The production of the film *Preserving Tradition, Embracing Change* and the Association's tort reform effort took priority over all other projects this year.

The production of the film *Preserving Tradition, Embracing Change*, premiered during the Opening Session of the OSMA House of Delegates, took much longer than expected to complete. The Council instructed the filmmakers to produce a film national in scope. The depth and complexity of current medical issues made final editing difficult and, at times, painful.

Despite the delay in completion, the film remains timely. It will be the Council's goal this year to generate wide distribution for the film both in Oklahoma and the nation. Preliminary discussions are underway with AMA officials to seek their assistance in marketing the film.

Council staff also became involved with the Oklahomans Against Lawsuit Abuse Coalition in assisting in production of reports and other public relations materials and the placement of news stories and editorials regarding the professional liability issue.

The Council also assisted the OSMA Auxiliary in two highly successful projects. Nearly 800 Medical Update placards were distributed by Auxiliary members and some 20,000 individual Medical Update brochures were distributed to Oklahoma physicians. The OSMA-OSMAA "MediFile" project was also a huge success. Nearly 170,000 cards were distributed. The project also generated favorable print and broadcast coverage throughout the state.

The Council also works actively to provide support for the OSMA's medical student programs which include annual picnics, roundtable discussions with practicing physicians, and advanced seminars with both state and national leaders. The programs are conducted on both the Oklahoma City and Tulsa campuses. There are now over 400 student members of the OSMA.

The development of a Speakers Bureau and production of an OSMA membership brochure are important projects that were not completed last year but will be given high priority in the year ahead.

The Council continued to publish the *OSMA News*, contribute to the *JOURNAL* of the Oklahoma State Medical Association, and work closely with members of the Oklahoma news media to provide news and public service information to the citizens of Oklahoma.

### Objectives

1) The primary objective of the Council will be to ensure wide distribution of the film *Preserving Tradition, Embracing Change*. Avenues for distribution will be public television or the direct purchase of broadcast time from commercial stations.

After initial showings, the Council will work to distribute the film for public service use to cable systems, commercial stations, hospitals with closed circuit television systems, and civic clubs.

The Council hopes to work with the AMA to achieve the above distribution on a national basis but must be prepared to act independently if necessary.

2) The Association and Council are pleased to announce a new relationship with KTOK radio in Oklahoma City, which runs the Oklahoma News network. The station has asked the OSMA President (or other appropriate member physician) to supply a 90-second editorial every month concerning medical issues. This is an excellent opportunity to bring the message of physicians to a large audience.

3) A new membership brochure for the OSMA will be another priority. None currently exists. The Council feels the brochure is needed to explain to members and potential members the work of our Association and the importance of membership.

4) The need for a Speakers Bureau is necessary for physicians to bring the message of medicine to the members of their community through talks before civic clubs, church groups, schools, etc. The Council will work to both publicize the existence of the Speakers Bureau and also supply materials necessary for public presentations.

5) The Council will continue to publish the OSMA News.

6) The Council will continue to produce Medical Update brochures as needed.

7) The Council will continue to support the public relations and public information needs of the Association as a whole, its Councils and Auxiliary.

#### Budget Requests

Print OSMA Brochure .....	\$ 7,000.00
Publish OSMA News .....	10,000.00
Print Medical Updates .....	4,000.00
Speakers Bureau .....	1,000.00
KTOK Editorials (production costs) .....	1,000.00
Community Service Projects .....	1,000.00
Educational Activities and Dues .....	3,000.00
Final Payment to Film Producers .....	23,000.00
Post Production Costs, Prints, Videotapes .....	5,000.00
Production, Marketing and Potential Air Time Costs for Film .....	45,000.00
<b>TOTAL</b>	<b>\$100,000.00</b>

Respectfully submitted,  
M. Joe Crosthwait, MD, Chairman  
Warren V. Filley, MD  
Burdge F. Green, MD  
Mary Anne McCaffree, MD  
Gary L. Massad, MD  
Lee L. Schoeffler, MD  
Michael R. Talley, MD  
Lanny F. Trotter, MD  
Lloyd Biby, MS III  
Stephen Lester, MS  
M. Michael Sulzycki, OSMA Staff

#### Progress Report Oklahoma State Medical Association Medical Student Program

Wilson D. Steen, PhD  
January 14, 1986

In 1983 two forces combined to precipitate a move to get students in medicine at the University of Oklahoma involved in organized medicine.

The Oklahoma State Medical Association approached me with a question of how the state association could become active in serving the medical students.

A short time later there were students at the medical school who wanted to become active in the state association. Steve Silverstein approached me about serving as faculty sponsor for a student division of the Oklahoma State Medical Association.

#### Programs Sponsored by OSMA

##### Picnics

August, 1985, the fourth annual picnic for first-year medical students was held on the front lawn of the medical association headquarters. A late cloud cover and northeast breeze turned this into the most successful of the picnics in terms of student participation in planning and attendance.

Picnics in 1984 and 1983 were at the Oklahoma Zoo Amphitheatre. Beautiful shade trees were somewhat off-set by the size and number of flies. The first picnic scheduled at Will Rogers Park was well attended but represented a complicated drive for the many students only in their first Oklahoma City week.



Ed L. Calhoun, MD, Beaver, compares notes with a colleague during the Opening Session of the House of Delegates.

The picnics scheduled for the last afternoon of the new student orientation program have had strong support from the College of Medicine, and in a few years now have become a quasi-part of the official orientation program. The Office of the Dean has supported this program both through endorsement and personal attendance.

Attendance by local physicians has increased each year. The convenience of OSMA headquarters seems to be a positive factor in physician attendance. The impact of the picnic on the new medical students is primarily influenced by the contact with practicing physicians. Therefore, a major objective of the picnic is to attain a ratio of one physician to each five or six medical students.

The Tulsa picnic started two years later. The first picnic was scheduled in a park some distance from town but provided a high quality environment. Last year (1985) the picnic was rained out and has not been rescheduled.

The annual picnics are an excellent activity to get the new medical students involved before they are buried under the "new body of knowledge." The location of the picnic at the OSMA headquarters is a big plus in that many students go through four years of medical school and never know where the OSMA headquarters is located.

##### Roundtables

July 23, 1982, Anita Delaporte wrote to the president of each of the specialty societies in Oklahoma. "The Oklahoma State Medical Association is undertaking a program this year to improve communication between medical students and organized medicine. The centerpiece of the program will be a series of roundtable discussions with medical students from the OU College of Medicine."

The fourth year of a very successful series of roundtable discussions (six each year) will be completed in April of 1986.

The program has had a tremendous response from the students. Participants have been selected on a lottery basis to ensure each student a fair chance to participate.

Over one hundred and thirty-five students have participated in these limited-enrollment roundtables.

Students have always played a key role in the topic selection, writing background papers, and hosting the roundtables. No less enthusiastic have been the invited speakers from the practicing physicians in Oklahoma. In four years no physician has refused to accept the invitation to present to the students. Some even have made multiple appearances.

Becky Adcock, a second-year medical student, wrote a paper, "The Roundtable: A Student's Point of View," (JOURNAL of the Oklahoma State Medical Association, Volume 76, No. 8, August 1983, pages 301-303) in which she discussed in detail the organization, speakers, and subjects in the first roundtable series. She ends with, "Its success indicates that the Oklahoma State Medical Association was able to introduce medical students to aspects of medical practice not covered in their regular course of study and provide them with an opportunity to explore their concerns relating to their role in organized medicine as practicing physicians."

The roundtables covered a variety of subjects and a wide range of presentors. In 1982-83 the Topics and Speakers were:

An Inside Look at Rural Medicine	Jack Parrish, MD
How Hospitals Work	Mr Charles Johnston Ken Pirtle, MD
Physicians and the Legislative Process	William Hughes, MD Mr Lyle Kelsey
Opening a Medical Practice: Where Business and Medicine Meet	Steven Brown, MD* Mr Ed Kelsay
Technology in Medicine	Tom Lynn, MD
The Oklahoma State Medical Association	John McIntyre, MD Mr David Bickham

\*Steve had to deliver a baby at the last minute.

1983-84:

Ethical Aspects of the Physician-to-Physician Relationship	Kent Braden, MD
Are Physicians and Hospitals Moving in the Same Directions?	Ronald Cramer, MD
Physicians' Lifestyle: The Impaired Physician	Ted Clemens, MD
Opening a Medical Practice: Where Business and Medicine Meet	Mr Ed Kelsay
Your Membership in the Oklahoma State Medical Association	George Kamp, MD

1984-85:

Technology and the Cost of Medicine	Tom Lynn, MD
Starting a Single or Small Group Practice, The Dollars and Cents Approach	Raymond Cornelison, MD
Time Management in the Medical Practice: Making Time for Self and Family	Claude Williams, MD
Medicine in Clinics (Teaching) vs Private Practice	Steve Krause, MD Mary Anne McCaffree, MD
Putting Preventive Medicine into Private Practice	Charles Atkins, MD
Your Membership in the Oklahoma State Medicine Association	J.B. Eskridge III, MD

(Offered in two sections)

1985-86:

The American Medical Association and You	Mr David Bickham
How the Hospitals Work	Harry Tate, MD
The Amazing Bowl of Alphabet Soup (government involvement)	Perry Lambird, MD
Physician to Physician, Some Ethical Issues	Kent Braden, MD
So You're Going to Practice Medicine (financial aspects of medicine)	Raymond Cornelison, MD
The Silent Conspiracy (The Impaired Physician)	Darrel Smith, MD

## Public Policy Seminar

The increasing response to the program sponsored by the OSMA precipitated a recommendation by the Roundtable Committee headed by MS II Pam Pierson.

There was evolving a pattern of preferred topics for the roundtables which were appropriate for first-year students. Students in the second year were interested in a different approach, so a four-seminar series was arranged. The four seminars were scheduled for two evening seminars in the fall semester and two seminars in the spring semester. The seminars were scheduled for the board room of the OSMA.

1985-86 Public Policy Seminars for Second Year Students:

How Hospitals Work	Mr Harry Neer
Physician-Physician — Ethical Issues	Mr George Short
So You Are Going to Practice Medicine	Mr Roger Harrison
The American Medical Association and You	Mr David Bickham

## Advanced Seminar

The Advanced Seminar started as an experiment in 1984-85 and was a very successful attempt to bring to the medical student a seminar based on major world issues other than medical topics.

Mr Henry Bellmon started the series with a seminar on World Hunger. Mr Robert Fulton spoke on World Poverty, while Mr Rod Frates discussed Futurism and Technology. The seminars were completed with a presentation from Dr Alex Kondonassis on Population.

There is now in place a program for first-year students, the luncheon roundtables, the second-year student, the public policy seminars, and the advanced seminars for the third- and fourth-year students.

These three programs involved over one hundred students during the school year.

In January 1984, three months after the first efforts to form a medical student chapter of the OSMA, there were 56 charter members of the chapter. These members elected representatives to the AMA, OSMA Board of Trustees, the House of Delegates, and to all standing councils. The students have participated in the OSMA activities and have been recognized by the chairmen of the councils as being welcome at the meetings.

In May of 1985 the Student Division of the Oklahoma State Medical Association was officially recognized by the House of Delegates. The Student Division held its first annual meeting on Saturday, May 4, in the Sheraton Century Hotel in Oklahoma City. Present membership in the Oklahoma County Oklahoma State Medical Association is 221. A major membership meeting is scheduled for January 1986.

During the past year the Tulsa County Medical Association has renewed its efforts for student participation.

An advanced Seminar series has been started and a membership meeting is scheduled for January. There is every indication that the students in Tulsa will be organized and will host the second annual meeting of the student division of the Oklahoma State Medical Association. There are currently 76 student members in Tulsa.

## Summary

A three-year effort to involve medical students in Oklahoma in the activities of the Oklahoma State Medical Association has been very successful.

Students have been responsive as have the physicians in the community.

The continuing development of the student organization in Oklahoma City and Tulsa and a unified student organization will provide the appropriate mechanics for students to move into active full-fledged membership when they enter their professional practice.

The potential for student participation in Council activities has only been partially realized. The potential action possibilities of student activity have yet to be explored.

More and more students are realizing that the medical world is changing and that they must be participants in the shaping of their own professional destiny.

## Recommendations

1. A committee review of the student activity progress in terms of goals and objectives.
2. A new statement of goals and objectives for the next four years.
3. A financial commitment to achieve these goals.

## Report of the COUNCIL ON PUBLIC AND MENTAL HEALTH

Subject: **Annual Report**

Presented by: George W. Prothro, MD, Chairman

Referred to: Reference Committee II

### Introduction

It is the goal of the Council on Public and Mental Health to provide the citizens of the state, as well as OSMA members, with timely information regarding the medical aspects of public health and to conduct and oversee needed programs in these areas.

### Review of Activities

The Council continues to be one of the most active and enthusiastic within the OSMA.

During the past year, the Council accomplished its two main objectives: 1) legislative language changes were achieved to "permit research, as approved by an appropriate institutional review board, on minors for reportable communicable diseases"; and 2) the Council, working in cooperation with the University of Oklahoma College of Medicine, the Oklahoma Department of Mental Health, and the Physician Manpower Training Commission Psychiatry Task Force, forwarded to the Governor and other appropriate state and education officials, a resolution calling for an increase in psychiatry residency positions, a wider geographical distribution of psychiatry residency positions, and more integration of the psychiatry training programs of the University of Oklahoma and the Oklahoma Department of Mental Health.



M. Joe Crosthwait, MD, Midwest City, chairman of the Council on Professional and Public Relations, steps to the microphone to introduce the film *Preserving Tradition, Embracing Change*, for which funds were allocated in last year's budget. Dr Crosthwait spearheaded the project.

The Council also reports as an information item that the Council's Nutrition Committee has ceased to function. Also, during the course of the year, the Council has established a constructive relationship with the OU College of Public Health and the OU Occupational Medicine Residency Program.

### Objectives

The Council views as its two main objectives for the coming year support and implementation of the Report of the Governor's Perinatal Task Force and providing physicians and patients timely information about Acquired Immunodeficiency Syndrome (AIDS).

*A. Governor's Perinatal Task Force:* The crisis in access and awareness of the need for perinatal care which already exists in Oklahoma will be made even worse this year due to the proposed cuts in state expenditures.

The Council has introduced and urgently recommends that the OSMA pass the Council's resolution supporting the Report of the Governor's Perinatal Task Force.

Since the charge of the Governor's Perinatal Task Force will expire with the term of Governor Nigh, the Council deems it imperative to restructure and recharge our Perinatal Task Force to work for the implementation of the goals and objectives in the Report of the Governor's Perinatal Task Force.

The Council recommends that the OSMA President appoint a current member of the Governor's Perinatal Task Force to chair and lead the Council's Perinatal Task Force activities.

*B. AIDS:* There are currently 50 known cases of AIDS in Oklahoma. Perhaps the biggest challenge for the OSMA will be to prevent misinformation, and in some cases, hysteria about AIDS. The Council recommends that the OSMA AIDS Task Force recommended by the Council on Planning and Development be made a function of the Council on Public and Mental Health. The Council will offer advice to the OSMA President concerning appointments to the OSMA AIDS Task Force.

In addition the Council through the OSMA AIDS Task Force will work to provide timely information regarding AIDS to physicians through the JOURNAL of the OSMA and the OSMA News and to patients through the Medical Update Series and other avenues for public awareness.

The Council will work closely with the Oklahoma Department of Public Health to provide AIDS information and recommends the OSMA cosponsor with the Department and assist with mailing and publicity for the Department's AIDS Update seminars throughout the state.

*C. Maternal Mortality Committee:* This Committee is established by Oklahoma Statute and operates independently of our Council and the Association. The Council encourages a closer liaison between the Maternal Mortality Committee and the Perinatal Task Force.

*D. Sports Medicine Committee:* Once again the Council will set as a priority the goal of establishing an active Sports Medicine Committee.

## Recommendations

1. Support and follow resolutions introduced by the Committee.
2. Continue activities as outlined by this report.
3. Approve the requested fiscal notes of this Council.

## Budget Requests

Council and Committee expenses . . . . .	\$ 500.00
Maternal Mortality Committee . . . . .	250.00
Other Council Programs and Internal Education Programs . . . . .	250.00
Total	<u>\$1,000.00</u>

Respectfully submitted,  
George W. Prothro, MD  
Edgar M. Cleaver, MD  
Gordon H. Deckert, MD  
Sara R. DePersio, MD  
Hayden H. Donahue, MD  
John W. Drake, MD  
Jodie L. Edge, MD  
George B. Gathers, Jr., MD  
William G. Harvey, MD  
Roger B. Hensley, MD  
Jerry R. Hordinsky, MD  
Greg Istre, MD  
Joe B. Jarman, Jr., MD  
Bertha M. Levy, MD  
Robert M. Mahaffey, MD  
John S. Muchmore, MD  
Jerry R. Nida, MD  
Edward K. Norfleet, MD  
Hal B. Vorse, MD  
Randall Webb, MS IV  
Melanie Russell, MS III  
M. Michael Sulzyski, OSMA Staff

## Report of the COUNCIL ON MEDICAL EDUCATION

Subject: **Annual Report**

Presented by: Irwin H. Brown, MD, Chairman

Referred to: Reference Committee II

## Introduction

The Council shall study and make recommendations related to all matters of maintaining or improving the level of competency of physicians in Oklahoma, including but not limited to, maintaining liaison with the medical education colleges in Oklahoma, to conducting continuing medical education courses for association members, and to the accrediting of medical education programs in Oklahoma. It will also monitor continuing medical education standards as they may be required by association policy.

## Activities

An important activity of the Council is the surveying and accreditation of institutions and organizations. The Council continues its activities of accrediting Oklahoma hospitals and independent organizations which meet the requirements. The OSMA has the sole responsibility, an extension of the national accrediting group, the Accreditation Council on Continuing Medical Education, of accrediting state CME entities. Presently, the following institutions are fully accredited to produce Category I Continuing Medical Education offerings:

Baptist Medical Center, Oklahoma City  
Duncan Regional Hospital, Duncan  
Hillcrest Medical Center, Tulsa  
Mercy Health Center, Oklahoma City  
Presbyterian Hospital, Oklahoma City  
South Community Hospital, Oklahoma City  
St. Anthony Hospital, Oklahoma City  
St. Francis Hospital, Tulsa  
St. John Medical Center, Tulsa

As this council reported in 1985, the OSMA Council on Medical Education was resurveyed by the ACCME to continue its accreditation as a surveying entity. We are happy to report that the results of the ACCME survey were highly complimentary. In a letter from Howard S. Madigan, MD, Chairman, Committee on Review and Recognition, he stated that the reviewers were favorably impressed with our CME Committee philosophy in regard to accreditation, as well as the caliber of the program which is in place for accreditation of a rather small number of institutions. The reviewers of our program did make some suggestions with which the Committee for Review and Recognition concurs. The recommendations are:

1. As a supplement to the annual report which you require from accredited institutions, it is suggested that specific information be provided regarding changes in the institution's accreditation related activities and/or administration of their CME program.

2. It is considered very desirable to present some tangible recognition to an accredited institution, ie, a certificate that may be displayed.

The Council on Medical Education will indeed carry out the reviewers' comments and suggestions.

## Recommendations

1. The OSMA continue its support of open communication with the Oklahoma medical schools, and encourage medical students to become more involved in organized medicine.

2. The OSMA actively encourage hospitals and other medical organizations to become accredited to produce continuing medical education programs for the state of Oklahoma.

3. The Council continue to send representation to local, state, and national education meetings when appropriate.

4. OSMA representatives participate in national accrediting surveys when asked by the Accreditation Council on Continuing Medical Education.

### Budget Request: \$1,000.00

The Council on Medical Education's budget request for 1986-87 is a 50% reduction in last year's request. As a means of sustaining Council operations, the Council on Medical Education has increased its resurvey fee from \$250.00 to \$350.00 effective this year.

Respectfully submitted.

Irwin H. Brown, MD, Chairman

John R. Alexander, MD

Robert C. Bowman, MD

Robert T. Buchanan, MD

Daniel Cogan, EdD

Robert W. King, Jr., MD

Steven Landgarten, MD

Thomas N. Lynn, Jr., MD

Harris J. Moreland, MD

Tim K. Smalley, MD

William R. Smith, MD

Edward J. Tomsovic, MD, Dean

Edgar W. Young, Jr., MD

Lorrie Hayes, MS II

Ross VanHooser, MS III

Robert W. Baker, OSMA Staff

## Report of the COUNCIL ON MEDICAL SERVICES

Subject: **Annual Report**

Presented by: John A. Blaschke, MD, Chairman

Referred to: Reference Committee II

### Introduction

The Council has been charged with the duties of studying and making decisions and formulating activities with respect to provisions of accurate medical care, including but not limited to the design of evaluation of all types of health care delivery systems, health planning, the financing of medical services and its impact on the quality of patient care, the social aspects of health, internal peer review mechanism, and the appraisal of all external programs which affect the cost and quality of medical care.

### Review of Activities

*A. Appropriateness Review Committee:* The Council continues to review cases when they deal with the quality and appropriateness of care. During the past year the Council has formally reviewed a dozen cases and addressed numerous other requests by encouraging closer communication between patients and physicians.

Council members deserve commendation for the many hours of thoughtful and difficult dedication they devote to their reviews.

*B. Fee Review Committee:* The Council's primary objective during the past year was to establish a Fee Review Committee. Rather than appoint a specific committee for fee review, the Council opted to have the Fee Review Committee function on an ad hoc basis, e.g., members of the Council will refer requests for review to respected colleagues around the state in the same specialty.

The Fee Review Committee will review inquiries from patients and, in rare instances, from insurance companies. The Committee will refer requests for review back to county societies which have established their own fee review committees. Currently Custer, Grady, Kingfisher, Oklahoma, Texas-Cimarron, and Tulsa Counties have fee review committees. The Council encourages all county societies to develop their own Fee Review Committees.

While the committee has adjudicated only two cases, the existence of the Committee has had positive impact. All complainants are instructed to personally contact the physician in question before filing a formal request for review. In at least six cases, this has resulted in an amicable settlement of differences.

*C. Vendor Drug Program:* This Committee, which consists of representatives from the OSMA, Oklahoma Pharmaceutical Association, and the Oklahoma Osteopathic Association, serves at the request of the Department of Human Services to advise the Department as to efficacious allocation of prescription medications to Medicaid patients.

The Vendor Drug Program Committee has met three times this year due to the fact that the DHS Vendor Drug Program budget will be cut from \$22 million to \$13 million next fiscal year.

OSMA members on the Vendor Drug Program Committee are: Edgar W. Young, Jr., MD; James D. Funnell, MD; and Jerry B. Vannatta, MD. Thomas L. Whitsett, MD, also serves on the Committee.

### Recommendations

1. The Council strongly supports the recommendation of the Council on Planning and Development that the OSMA establish a Committee on Ethics and Clinical Competency. This Committee is much needed. The Council recommends that a Committee on Ethics and Clinical Competency be separate and distinct from the Council on Medical Services.

2. Through the advice of the OSMA President and Board of Trustees, the charge to the Council on Medical Services should be reevaluated. Because of its peer review, and now fee review, activities, this Council has gradually evolved as a "catch all" resting place for problems that do not quite fit anywhere else. A Committee on Ethics and Clinical Competency will go a long way in alleviating the problem and providing the Council the opportunity to have the time to evaluate and make recommendation concerning our health care delivery system, its funding and effects on patient care.

3. The Council will continue its appropriateness review activities.

4. The Council will continue its fee review activities.

5. The Council will continue to support the Physician Manpower Training Commission and its physician placement program.

6. The Council will continue its liaison with allied health professional organizations.

## Budget Requests

Council Meeting Expenses .....	\$ 1,000.00
Total .....	\$ 1,000.00

Respectfully submitted,  
John A. Blaschke, MD, Chairman  
Ronald S. Barlow, MD  
Donald L. Cooper, MD  
G. Kevin Donovan, MD  
Kurt Frantz, MD  
Jay A. Gregory, MD  
Bartis M. Kent, MD  
Gretchen A. McCoy, MD  
Ray V. McIntyre, MD  
John R. Perkins, MD  
Ed E. Rice, MD  
David J. Shepherd, Jr., MD  
Rebecca Worrell, MS IV  
Cynthia Alsup, MS III  
M. Michael Sulzyski, OSMA Staff



New OSMA Auxiliary President Kelsey Walters, Oklahoma City, briefs the House of Delegates on her goals for the coming year. Her theme will be "motivate our volunteers with enthusiasm."

## Report of the SECTION ON HOSPITAL MEDICAL STAFFS

### Subject: Annual Report

Presented by: Orange M. Welborn, MD, Chairman  
Referred to: Reference Committee II

### Introduction

During its 1985 Annual Meeting, the OSMA House of Delegates adopted special amendments to its bylaws calling for the creation of the three sections: Hospital Medical Staff Section, Medical Student Section, and Resident Physicians Section. At the Opening Session of the 1986 House of Delegates (this year) the House will consider the appropriate amendment to the OSMA constitution which will allow a delegate and/or alternate delegate from the three new sections to be seated immediately and participate in the 1986 House deliberations. The purpose of the new Section is to provide a direct means whereby the Medical Association can address the relationship among members of the OSMA, hospital medical staffs, and hospitals.

### Organizational Meeting

The organizational meeting of the Hospital Medical Staff Section was conducted March 16, 1986, in Oklahoma City. At that time, the assembled hospital representatives adopted a set of bylaws creating a Governing Council for the Section to consist of a Chairman, Vice-Chairman, Secretary, OSMA Delegate and Alternate Delegate, and six Members-At-Large. The Governing Council will conduct the business of the Section in the interim between annual Section meetings.

Each hospital in the state is allowed to be represented by one medical doctor delegate to the Section Annual Meeting, and all such delegates are eligible for election to the Governing Council. The Council members shall serve staggered terms except for the Chairman and the Delegate and Alternate Delegate to the OSMA House of Delegates.

The Chairman of the Council shall be appointed by the President of the Oklahoma State Medical Association, since the Section is a part of the OSMA's council and committee structure. The delegate and alternate, according to the bylaws of the Association, can only serve on a year-to-year basis.

The bylaws of the Council will be formally approved by the OSMA Board of Trustees during the Annual Meeting.

### Initial Activities

During its organizational meeting, the Hospital Medical Staff Section approved the following concepts and ideas:

First, that the Section should be available to assist in the mediation or arbitration of medical staff disputes between the individual Hospital Medical Staff member and the hospital staff, and between the Hospital Medical Staff and the Hospital Board of Control. Willingness to arbitrate in such disputes should be publicized to all hospitals.

Second, the OSMA, through the Hospital Medical Staff Section, should offer Hospital Medical Staffs assistance in evaluating, upgrading, and/or rewriting their current Hospital Medical Staff bylaws.

Third, the Medical Staff Section should seek a budget of at least \$5,000 for fiscal year 1985-86 to offset its expenses.

Fourth, all members of the OSMA, and especially hospital representatives, should be invited to attend any Section meeting or meeting of the Section Governing Council.

And, Fifth, the Annual Meeting of the OSMA Hospital Medical Staff Section should be set by the Governing Council every year at least 30 days prior to the Planning and Development Council's spring meeting.

### Governing Council

The following members were elected to the first Governing Council of the new Section:

Chairman, Orange M. Welborn, MD, Ada (appointed by OSMA President)

Vice-Chairman, Sterling Baker, MD, Oklahoma City

Secretary, Eugene Bell, MD, Tishomingo

Delegate, David Russell, MD, Enid

Alternate Delegate, Bruce Storms, MD, Chickasha

At-Large-Member #1, William Coleman, MD, Oklahoma City

At-Large-Member #2, A.C. Roberson, MD, Anadarko

At-Large-Member #3, Douglas Brant, MD, Bethany

At-Large-Member #4, David Rose, MD, Ardmore

At-Large-Member #5, Pat Tinker, MD, Bartlesville

At-Large-Member #6, Joe Coker, MD, Elk City

Respectfully submitted,  
Orange M. Welborn, MD, Chairman  
Hospital Medical Staff Section

## Report of the JOURNAL OF THE OKLAHOMA STATE MEDICAL ASSOCIATION

An Addendum to the Report of the  
Council on Professional and Public Relations

### Subject: Annual Report

Presented by: Mark R. Johnson, MD, Editor-in-Chief

Referred to: Reference Committee II

### Introduction

The JOURNAL of the Oklahoma State Medical Association has maintained its position as one of the nation's finest medical publications by providing its readers with timely, significant scientific articles and special feature stories. The JOURNAL remains a very popular and important benefit of membership in the association.

In January of this year, the JOURNAL introduced a new logo, cover format, and letterhead design as part of its ongoing effort to improve readability and recognition.



Perry A. Lambird, MD, (right) Oklahoma City, member of the AMA Council on Member Service, welcomes AMA Medical Society Relations Officer Kevin Walker to the Tulsa meeting.

The "Leaders in Medicine" series will continue to be a feature in selected issues. The articles will focus on Oklahoma physicians who have made significant contributions to Oklahoma medicine and who, in the opinion of the Editorial Board, deserve to be recognized for their accomplishments. Featured in 1985 were William C. McCurdy, Jr., MD (March), and W. W. Rucks, Jr., MD (October).

The Editorial Board, at its annual meeting in March, selected the winners of the \$500 Charlotte S. Leebron Memorial Trust Award, given annually to the author(s) of the best scientific paper published in the JOURNAL the preceding year. The 1985 award will be shared by Don P. Wilson, MD; Nancy J. Carpenter, PhD; and John H. Holcombe, MD, for their paper "Turner Syndrome: Clinical Investigations and Review," which appeared in the February 1985 issue. The award is presented at the OSMA's Annual Meeting each May.

In further action the Editorial Board voted to implement a 10% increase in display and miscellaneous advertising rates, effective January 1, 1987. The action was in response to notification by The Transcript Press that its rates for printing the JOURNAL will be increased on July 1, 1986.

Respectfully submitted,

Mark R. Johnson, MD  
Editor-in-Chief

Harris D. Riley, MD  
Editor

Robert G. Tompkins, MD  
Editor

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## Reference Committee III

# REPORTS TO THE HOUSE OF DELEGATES

### Report of REFERENCE COMMITTEE III

Presented by: R. Kern Jackson, MD, Chairman

Mr Speaker and Members of the House of Delegates:

Reference Committee III gave careful consideration to the several items referred to it and submits the following report:

(1) *Report of the Council on Governmental Activities*  
Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Governmental Activities be adopted.

Reference Committee III heard a well organized report from Perry A. Lambird, MD, Council Chairman, concerning the status of federal legislation and national developments as they pertain to the medical profession. Dr Lambird mentioned to the committee that through the Washington liaison, John Montgomery, we have continued to maintain an excellent working relationship with the entire Oklahoma Congressional Delegation. Council recommendations included the further examination of the AMA Council on Medical Services' report dealing with medical IRAs. Continuation of our support for a single statewide Medicare reimbursement zone and to wholeheartedly oppose the single, nationwide contractor for military dependents health care. Dr Lambird expressed his appreciation to the OSMA staff and to the entire council for their dedication.

(2) *Report of the Council on State Legislation*  
Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on State Legislation be adopted.

Reference Committee III heard from the OSMA Director of State Legislation, Otie Ann Carr, regarding the numerous legislative bills considered by this council. It was made clear by Ms Carr to the Reference Committee that although this year has been a very difficult one legislatively, the council has diligently represented organized medicine's interest to the highest degree. It was stressed that our success or failure this legislative session is only the beginning of our efforts to pass meaningful tort reform. Ms Carr was most appreciative of the increased physician and spouse political participation at the Capitol. This Reference Committee recognizes the near insurmount-

able opposition to tort reform in the legislature. However, the committee is encouraged by this council's efforts and is optimistic that success is not far away.

(3) *Report of the Council on Member Services*  
Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Council on Member Services be adopted.

Dr William O. Coleman, Chairman of the Council on Member Services, reviewed for the committee the numerous responsibilities charged to this council. This Reference Committee wishes to congratulate Dr Coleman and the members of this council for their in-depth work and maintenance of the underwriting program for professional liability insurance through PLICO.

(4) *Report of the Oklahoma Medical Political Action Committee*  
Recommendation:

Mr Speaker, your Reference Committee recommends that Report of the Oklahoma Medical Political Action Committee be adopted.

Reference Committee III was very pleased with the membership figures of OMPAC for 1985-86. The committee wishes to congratulate the dedication of Dr Larry Long, Robert W. Baker, and Ann McWatters for their undying devotion in an area that deserves this association's entire support both financially and politically.

(5) *Report of the Physician Recovery Committee*  
Recommendation:

Mr Speaker, your Reference Committee recommends that the Report of the Physician Recovery Committee be adopted.

Reference Committee III perused the Physician Recovery Committee's report and feels that it is truly one of the finer programs of the OSMA. The committee would like to congratulate program director, J. Darrel Smith, MD, for a job well done.

(6) *Resolution 8 — Opposition to Dual Fees*  
Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 8 not be adopted.

Resolution 8 is a poorly worded reiteration of existing OSMA policy. The Reference Committee questions the value of an effort to inform all third-party payers of association policy.

(7) *Resolution 11 — Mandatory Assignment*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 11 be adopted as amended.

The Reference Committee recommends amending line 17 following the word *assignment* by deleting the language *including but not limited to* and inserting the language *which might include the following*.

Resolution 11 asks that the OSMA take whatever measures necessary to prevent mandatory assignment by various means. Although this committee wholeheartedly endorses the opposition to mandatory assignment, the committee feels that the resolve was too stringent.

(8) *Resolution 16 — Formation of a Non-Profit HMO by OSMA*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 16 not be adopted.

Your Reference Committee discussed in great detail Resolution 16 pertaining to an OSMA-owned HMO. The competitive nature of HMOs-IPAs and similar forms of delivery systems requires stringent utilization review programs that may exclude some physician members because of practice preference or patterns. Such actions would have the effect of placing the association member in competition with his own association. Necessary disciplinary actions to preserve the financial integrity of the HMO-IPA, etc., based on economic consideration could conflict with the association's traditional role of evaluating clinical competency and medical judgment. In addition, your physician-sponsored HMOs-IPAs, etc., in Oklahoma that would be in competition with OSMA.

(9) *Resolution 20 — OSMA Annual Meeting*

Recommendation:

Mr Speaker, your Reference Committee recommends that Resolution 20 be adopted.

Your Reference Committee heard much discussion on Resolution 20 which authorizes the President of the OSMA to discontinue the sale of exhibit spaces and the medical science programs conducted in conjunction with the OSMA Annual Meeting. The committee believes that this new direction may very well decrease the large expenditures attributed to our annual meeting, as well as be able to address all of the important business items of the association in fewer working days.

Mr Speaker, this concludes the report of Reference Committee III. Your Reference Committee wishes to thank all who participated in the hearing and contributed to the preparation of this report and as chairman of this Reference Committee, I would like to express my appreciation to the committee members and staff for their time and effort.

Respectfully submitted,

R. Kern Jackson, MD, Chairman

Schales L. Atkinson, MD

Curtis O. Bohlman, MD

Philip C. Bryan, MD

Jerry L. Puls, MD

Rollie E. Rhodes, Jr., MD

Rebecca Goen Tisdal, MD

Richard L. Winters, MD

Robert W. Baker III, Staff

Ann McWatters, Staff

## Report of the COUNCIL ON GOVERNMENTAL ACTIVITIES

Subject: **Annual Report**

Presented by: Perry A. Lambird, MD, Chairman

Referred to: Reference Committee III

### Introduction

The Council shall review federal legislation and regulation of concern to the medical profession or the public health, and shall initiate activities or undertake appropriate responses on matters of priority interest. It shall also establish and maintain relations with federal government entities having statutory or regulatory jurisdiction affecting the medical profession, the delivery of health care, or the public health. In cooperation with other association councils and committees, it shall develop policy recommendations for consideration by the Board of Trustees, and it shall prepare testimony and otherwise conduct the federal legislative program of the association.

### Washington Activities

In the final moments of the First Session of the 99th Congress, it became clear that the final action before adjournment would center on whether the budget reconciliation proposal, HR 3128, would be sent to the President. HR 3128 would have made numerous modifications to federal programs, including Medicare and Medicaid, and it carried a savings tag of approximately 80 billion dollars over the period of FY86-FY88. However, the House and Senate could not agree over the funding mechanism for the "super fund" program and they participated, as characterized by Rep. Martin (R-IL), in a game of legislative maneuvering. The outcome of the maneuvering was that neither side was willing to yield, and Congress went home without acting on reconciliation.

Even though Congress was unable to agree on reconciliation, they did act to prevent the Medicare reimbursement and fee limitations (originally scheduled to sunset on September 30th) from expiring. Congress extended these limi-



Letter jackets and sweaters, jeans, white bucks, and saddle shoes were the appropriate dress at the OU College of Medicine Alumni Dinner Thursday night. Pink and black balloons bobbed above the tables during this year's "High School Hijinks." Dr Robert J. Weedn, Duncan, here sporting his favorite jeans and letter jacket, and his wife, Julie, won the prize for best costumes.

tations for a fifth time, this time until March 14, 1986. They also extended the hospital reimbursement freeze and maintained the sixteen cents per pack cigarette tax through March 15, 1986. Now that Congress has reconvened, it is uncertain whether it will return its attention to HR 3128 or go straight to the FY87 budget proposals. The White House has already indicated that it will again seek a freeze on physician Medicare reimbursement programs in its FY87 budget proposals. As of March 19, 1986, attempts to resolve the 1986 budget reconciliation process again have gone nowhere as the House and Senate remained adamant in their positions. Each of the Houses insists that its own bill be adopted and has refused to budge. Disagreement centers on areas *not* involving physician reimbursement under Medicare Part B. The House and Senate have reached agreement on physician reimbursement provisions for the remainder of the year. The physician reimbursement provisions will continue *and be made retroactive*. The fee freeze on "nonparticipating" physicians continues through the calendar year and grants, effective May 1, a 4.15 percent increase in reimbursement

to those "participating physicians" whose fees do not exceed prevailing charge levels. These identical provisions are contained in the budget reconciliation bills approved by the two Houses in early March. The only remaining question pertaining to fee freezes is whether these approaches will be implemented through an ultimate budget reconciliation bill or via an extender bill.

Even though the current fee and reimbursement fees technically expired on March 14, 1986, Congress made it clear that it intends, retroactively, to roll back any fee increases made since then.

In mid-March, HCFA issued a press release advising that PROs are being directed to examine raw data suggesting that discharge and mortality rates may be either too high or too low in as many as 2,300 hospitals. HCFA said it is making the survey data available to the public "because we feel the public ought to have as much information as possible about the Medicare program." The AMA cautioned the public against drawing any conclusions from the hospital release and mortality statistics from the Department of Health and Human Services, stating that the data should only be interpreted along with other pertinent information.

Tort reform is the new catch phrase sweeping the country. As many as 46 state legislatures are addressing some components of tort reform at the present time. As was earlier reported, Congress has taken a legislative role in professional liability legislation as well through the introduction of S.1804. Presently, S.1804, AMA's professional liability bill, by Senator Orrin Hatch of Utah and coauthored by Senator Don Nickles of Oklahoma, is preparing for upcoming Senate hearings. Our association, through this Council, has been in constant discussions with Senator Nickles' office pertaining to the hearing. Senator Nickles has been most receptive to our Oklahomans Against Lawsuit Abuse Coalition and is planning to have an individual spokesperson from this coalition participate in the hearings now scheduled for late May, 1986. The hearings for S.1804 are scheduled for the Senate Labor and Human Resources Committee. Although passage of S.1804 in this Congressional year seems unlikely, the emphasis being placed on professional liability reform nationwide has forced the tort reform issue to be heard and action taken. This Council, in conjunction with the OSMA Coalition, will continue to work towards the passage of S.1804 or any similar tort reform legislation in the months ahead.

The Senate has postponed action on Senator David Boren's amendment, a proposal that would place major limitations on amounts Senate and House candidates could receive from political action committees and on the amounts which could be donated to PACs in general. The amendment by Boren was offered to a low-level radioactive waste bill. It would limit House candidates to accepting a maximum of \$100,000 in PAC contributions with another \$25,000 if they faced opposition in both primary and general elections. A Senate candidate could accept \$175,000 to \$750,000 depending upon the size of the state. The amendment would also lower the ceiling on individual PAC contributions from \$5,000 to \$3,000 per election and increase maximum individual gifts from \$1,000 to \$1,500.

The Senate avoided a showdown vote on the measure when supporters and opponents joined together to call for hearings from the Senate Rules Committee early this year on Boren's plan, as well as other campaign finance proposals. Presently, the PAC bill is being studied and has recently had Congressman Mike Synar's amendment added to the legislation. Congressman Synar's amendment would push for public financing of Senate and House congressional campaigns. It should be noted that OMPAC is adamantly opposed to the Boren legislation, as the political action committee feels that the small individual contribution made by our physicians to the PAC promotes good political awareness and will continue to have the voice of Oklahoma medicine heard on both the state and federal level. OMPAC does not concur with the public financing proposed by Congressman Mike Synar.

There will be no more radio and TV advertising of smokeless tobacco by the time the fall school term starts. The ban on advertising in the voice media is one of the restrictions in the Comprehensive Smokeless Tobacco Health Education Act that President Reagan signed into law earlier this month. That provision becomes effective six months from the date of enactment. The new law also



Elvin M. Amen, MD, (right) presents his successor, Norman L. Dunitz, MD, with the green ribbon and bronze medallion symbolic of the OSMA presidency.

requires that health warnings be placed on all smokeless tobacco packaging and also be prominently mentioned in any printed advertising. Enactment of the measure was strongly supported by the AMA, the OSMA, the American Heart Association, the American Cancer Society, the American Lung Association and other medical organizations. Prior to enactment, Massachusetts was the only state that required health care warnings to be placed on smokeless tobacco products. Had Congress not acted, however, about 25 states had indicated plans to consider adoption of similar statutes.

On Friday, January 17, 1986, President Reagan vetoed a measure that would have permitted nurses and certified nurse midwives to be directly reimbursed for services provided to federal employees under the Federal Employees Health Benefit Plan. The veto kills the bill, HR 3384. The OSMA, AMA, and this Council supported the Presidential veto of the bill because it would have amended the Federal Employees Health Benefit Plan to require that patients be provided "direct access to care without supervision or referral of another health practitioner." This measure authorized nurses and certified nurse midwives to direct reimbursement. As Congress held no hearings on this legislation, the veto by President Reagan was especially important.

### Council Actions

The Council on Governmental Activities has made the following motions in regard to Washington activity:

The Council recommends:

- (1) To hold off pursuing the OSMA Medicare Demonstration Project until it has reviewed the soon-to-be-released AMA Council on Medical Services report regarding medical I.R.A.s and vouchers.
- (2) To continue to urge the support for a single-statewide reimbursement zone for Medicare.
- (3) To oppose a single, nationwide contractor for military dependents' health care.
- (4) To pursue, with our Congressional Delegation, discussions pertaining to the possibility of a statewide Pilot Project involving the voucher system.

## Conclusion and Recommendations

The OSMA will continue sending delegates to Washington, DC, to meet with our Congressional Delegation. This Council will continue to monitor Congressional action daily, and we will continue to report on legislation as it is introduced. The continuation of Mr John Montgomery as the OSMA Washington liaison is recommended by this Council.

## Budget Request: \$27,500.00\*

\*Does include salary of John Montgomery

Respectfully submitted,  
Perry A. Lambird, MD, Chairman  
Richard J. Boatsman, MD  
William D. Borkon, MD  
Theodore J. Brickner, Jr., MD  
Ed L. Calhoon, MD  
Charles D. Cook, MD  
Jerome M. Dilling, Jr., MD  
Jay A. Gregory, MD  
Curtis E. Harris, MD  
Mark A. Hayes, MD  
George H. Kamp, MD  
Lee N. Newcomer, MD  
George M. Pikler, MD  
Christian N. Ramsey, Jr., MD  
Ronald H. White, MD  
William L. Hughes, MD  
Mary Ann Deen, Auxiliary  
Vaughn Dean Fuller, Auxiliary  
Ellie Idstrom, Auxiliary  
Veronica Montero, Auxiliary  
John Montgomery  
Joe Andrezik, MS IV  
Jim McGouran, MS II  
Robert W. Baker, OSMA Staff

## Report of the COUNCIL ON STATE LEGISLATION

Subject: **Annual Report**

Presented by: William L. Hughes, MD, Chairman

Referred to: Reference Committee III

Presently, the 40th Session of the Oklahoma State Legislature is going through numerous stages of political maneuvering as they prepare to adjourn in May and gear up for their respective reelection campaigns. This Council has once again worked feverishly to represent the Oklahoma State Medical Association on virtually every bill pertinent to medicine and the proper delivery of health care.

The Council on State Legislation met numerous times in 1986 and took a position on over 38 bills, some of which were carried over from the first half of the 40th legislature 1985. The CONTACT program, initiated in 1985, has continued to be a viable source of grass roots support for the Council's positions, with membership now over 700. We have seen, through numerous bills and especially tort reform, the value of the CONTACT program. Through CONTACT we have been able to develop more personal relationships with members of the legislature as well as promote greater political awareness to our membership.

This Council would like to take this opportunity to thank all members of the CONTACT program; once again, it is working. The Council would also like to urge all OSMA members to join OMPAC, the Oklahoma Medical Political Action Committee.

As I noted in last year's report, the three components of a successful legislative campaign are (1) a personal relationship with your legislator through CONTACT; (2) a strong political action committee; and (3) local political involvement.

Our success or failure in the legislature is directly connected to the above named components. We urge your involvement and participation. Medicine depends on it!

## Budget Request: \$65,000.00

Respectfully submitted,  
William L. Hughes, MD, Chairman  
Nolen L. Armstrong, MD  
Theodore J. Brickner, Jr., MD  
M. Tom Buxton, Jr., MD  
Hugh M. Conner, Jr., MD  
Raymond L. Cornelison, Jr., MD  
Billy D. Dotter, MD  
Robert S. Ellis, MD  
William P. Jolly, MD  
John F. Josephson, MD  
William J. Kruse, MD  
Steven A. Mueller, MD  
Lee N. Newcomer, MD  
Gary L. Paddack, MD  
Michael J. Schwartz, MD  
Charles R. Vest, MD  
Edgar W. Young, Jr., MD  
Mark R. Johnson, MD  
Perry A. Lambird, MD  
Joan K. Leavitt, MD  
Larry L. Long, MD  
Walter H. Whitcomb, MD  
George F. Short, Attorney  
Vaughn Dean Fuller, Auxiliary  
Ellie Idstrom, Auxiliary  
Veronica Montero, Auxiliary  
Stuart Jackson, MS III  
Melanie Russell, MS II  
Otie Ann Carr, OSMA Staff

## STATUS OF SENATE BILLS

April 15, 1986

The following is a list of the legislation monitored by the Oklahoma State Medical Association:

- \*SB 122 **Allowing plaintiffs to dismiss civil actions without prejudice** 10 days before the trial date. OSMA POSITION: Support. STATUS: Dead.
- \*SB 123 **Limiting percentage of liability when two or more defendants are involved** in negligence or product liability case. OSMA POSITION: Support. STATUS: Dead.
- \*SB 127 **Providing that information concerning conditions and treatment of patients is subject to discovery** by parties to a medical malpractice suit. OSMA POSITION: Strongly oppose. STATUS: Dead.
- SB 176 **Adding psychologists to the definition of physician** in the Worker's Compensation Act. OSMA POSITION: Oppose. STATUS: Conferees unable to agree — returned to Senate pending consideration of House amendments.
- SB 219 **"Alcoholism and Drug Dependency Treatment Insurance Act."** To include benefits for the treatment of the illness of alcoholism and drug dependency in all health insurance contracts issued in this state. OSMA POSITION: Monitor. STATUS: Dead.
- SB 261 **Restructuring the size and composition of various boards and commissions** in accordance with the Oklahoma Boards and Commissions Uniform Districting Act. OSMA POSITION: Support. STATUS: Died in committee.
- \*SB 265 **Setting interest rates on certain judgments** by courts of record. OSMA POSITION: Actively support. STATUS: Died in committee.
- \*SB 310 **Modifying interest rates on judgments** by courts of record. OSMA POSITION: Support. STATUS: Died in committee.
- SB 311 **Defining usual, customary, and reasonable fees** charged by healing arts practitioners. OSMA POSITION: Oppose. STATUS: Died in committee.
- SB 342 **Allowing establishment of preferred provider insurance policies;** requiring insurer to establish conditions to be met by health care providers. OSMA POSITION: Oppose. STATUS: Died in committee.
- SB 461 **"Executive Branch Reform Act of 1986."** OSMA POSITION: Monitor. STATUS: Passed House, returned to Senate for consideration of amendments.
- SB 488 **Authorizing the Insurance Commissioner to create joint underwriting associations** of liability insurers. OSMA POSITION: Monitor. STATUS: Amended & passed House, returned to Senate for consideration of amendments.
- SB 496 **Creating a Workers' Compensation Appellate Court;** changing statutes regarding sole proprietors and liability of private employers of public employees; providing medical fee schedule; changing length of duration of certain time period and benefits. STATUS: Com. Sub Passed from House Industry & Labor Relations Committee.
- SB 522 **Requiring physical therapist assistants to be licensed.** OSMA POSITION: Oppose. STATUS: Died in House Public Health Committee.
- SB 528 **Prohibiting spinal examinations by manipulation by persons not licensed and trained in chiropractic, medicine, or osteopathy.** OSMA POSITION: Monitor. STATUS: Amended and passed House, returned to Senate for consideration of amendments.

## STATUS OF HOUSE BILLS

April 15, 1986

- \*HB 1100 **Providing for joint and several liability of joint tortfeasors** for single harm. OSMA POSITION: Oppose. STATUS: Died in committee.
- \*HB 1172 **Providing that contributory negligence shall not prohibit recovery** for certain damages; limiting liability to the percentage of negligence. OSMA POSITION: Support. STATUS: Died in committee.
- \*HB 1195 **Allowing for defense of contributory negligence in product liability** court actions. OSMA POSITION: Support. STATUS: Died in committee.
- HB 1223 **Prohibiting certain health care professionals and others from charging for diagnostic tests** unless they supply patient with certain information. OSMA POSITION: Oppose. STATUS: Died in committee.

- HB 1230 **"Uniform Determination of Death Act."** OSMA POSITION: Support. STATUS: Amended & passed Senate, returned to House for consideration of amendments.
- HB 1231 **Providing for placement or destruction of certain animals** and prohibiting making random-source animals available for research, testing, or experimentation. OSMA POSITION: Oppose. STATUS: Died in committee.
- HB 1318 **Oklahoma Occupational Hearing Loss Act.** OSMA POSITION: Oppose. STATUS: Dead.
- HB 1371 **"Oklahoma Health Research Act";** creating Oklahoma Health Research Commission; levying an excise tax on all health and accident insurance and life insurance premiums, to be deposited in the Health Research Fund. OSMA POSITION: Support. STATUS: Amended & passed Senate, returned to House for consideration of amendments.
- \*HB 1378 **Providing that no person shall be held civilly liable for any act or omission** that results in a person being born alive instead of being aborted. OSMA POSITION: Actively opposed. STATUS: Died in committee.
- HB 1497 **Modifying definition of disease to include acquired immunodeficiency syndrome (AIDS).** OSMA POSITION: Monitor. STATUS: House rejects Senate amendments & requests a conference.
- HB 1645 **Prohibiting the removal of a human dead body or any part thereof without authorization** by a peace officer or medical examiner. OSMA POSITION: Monitor. STATUS: House rejects Senate amendments and requests conference.
- HB 1752 **"Dispensing Physician Act";** requiring physicians to be licensed by their respective boards to dispense drugs requiring a prescription. OSMA POSITION: Support. STATUS: Died in committee.
- HB 1754 **Providing for the commitment of drug-dependent persons** to medical facilities or any other facility certified for the treatment, counseling, rehabilitation, and such other related services for drug-dependent persons. OSMA POSITION: Monitor. STATUS: Died in committee.
- HB 1771 **Requiring physicians to report residential and occupational history** to the State Department of Health of persons diagnosed as having cancer and parents whose children are born with birth defects; prohibiting disclosure of certain information without written consent. OSMA POSITION: Pending. STATUS: Signed by the Governor.
- HB 1840 **Authorizing health-care facility employees authorized to withdraw blood** to perform this function for the purpose of determining the concentration of intoxicating substances in the blood. OSMA POSITION: Support. STATUS: Signed by the Governor.
- HB 1842 **Providing for reasonable compensation for practitioners** licensed under the healing arts. OSMA POSITION: Support. STATUS: Amended & passed Senate, returned to House for consideration of amendments.
- HB 1883 **Modifying planning and assistance provisions** relating to discharge of persons from mental health facilities. OSMA POSITION: Support. STATUS: Signed by Governor.
- HB 1892 **Establishing limitations on certain damage awards** arising out of liability actions; limiting interest rates on judgments. OSMA POSITION: Actively Support. STATUS: Amended & passed House, returned to Senate for consideration of amendments.
- HB 1893 **Modifying definition of institutional health service,** increasing affected capital expenditures to \$2 million and deleting acquisition of major medical equipment from oversight of the Oklahoma Health Planning Commission. OSMA POSITION: Monitor. STATUS: House rejects Senate amendments and requests conference.
- HB 1935 **Requiring tests to determine the presence of antibodies** to the human T-lymphotropic virus type III prior to marriage; providing penalty. OSMA POSITION: Oppose. STATUS: House rejects Senate amendments and requests conference.
- HB 1946 **"Nine-One-One Emergency Number Act."** OSMA POSITION: Support. STATUS: Returned to House for consideration of amendments.
- HB 2005 **Triplicate Prescription.** OSMA POSITION: Support with provisions. STATUS: Died on House floor.
- HB 2053 **Modifying provisions of the Worker's Compensation Act.** STATUS: House rejects Senate amendments and requests a conference.

\*These are anti-trial attorney bills that were introduced by other associations. Anti-trial attorney bills introduced at the request of the OSMA.

## Report of the COUNCIL ON MEMBER SERVICES

Subject: **Annual Report**

Presented by: William O. Coleman, MD, Chairman

Referred to: Reference Committee III

### Introduction

It is the responsibility of the Council on Member Services to monitor and develop programs that offer direct benefits to physician-members of the OSMA. These include a variety of sponsored insurance programs — including the successful professional liability coverage through PLICO and PLICO's health insurance. (See Attachment 1.) Additionally, the Council supervises the OSMA-sponsored tours and offers numerous other programs each year for members.

The Council is also charged with the responsibility of supervising and maintaining the underwriting program for professional liability insurance through PLICO. This is a contracted function between the OSMA and the PLICO management company, C. L. Frates, Inc.

### Review of Activities

*A. For-Profit Corporation* — One of the Council's primary functions this year, 1985-86, was the creation of a for-profit corporation. The corporation was authorized by the OSMA House of Delegates during its 1985 meeting and implementation was ordered by the Board of Trustees during its November, 1985, meeting.

The corporation, known as the OSMA Member Services Corporation, will begin to handle those member service functions of the OSMA that might tend to produce a profit. The primary purpose of the corporation will be to allow the Association to conduct for-profit functions without fear that the IRS might attack the Association's non-profit status because of the unrelated income rules.

The Council has now begun to move some of the various seminars, tours, etc., over to sponsorship under the auspices of the corporation.

*B. England Tour* — The Council approved the sponsorship of a tour to England to be conducted by Vantage Travel Company in June of 1986. A special medical-legal seminar will be conducted in conjunction with the tour on the subject of "Professional Liability: Possible International Solutions."

*C. Seminar Report* — In 1985, the Council began an expanded series of medical office management and personal financial management seminars for physicians under Medical Office Personnel. With only one exception, all of the seminars have shown a profit.

The Financial Planning Program, offered in Oklahoma City and Tulsa in late 1985, showed a slight loss, while the Workers' Compensation Program, offered in Oklahoma City in October, had a profit of approximately \$2,000. Two other seminars offered in Oklahoma City and Tulsa, Medicare Billing and Law for the Medical Office, offered in early November, 1985, developed a profit slightly in excess of \$6,000.



Michael J. Haugh, MD, Tulsa, chairman of the OSMA Board of Trustees, presents the board's 1985-86 report to the House of Delegates.

In August of 1985 and again in February of 1986, the Council sponsored a series of four half-day seminars in both Oklahoma City and Tulsa. Each of the half-day programs was taught by Ed Kelsay, OSMA Legal Counsel. After all the expenses were paid for the programs, a profit slightly in excess of \$8,000 was realized.

Two "Gearing Up For Retirement" programs jointly sponsored by the OSMA and the AMA were conducted in February and developed approximately \$1,000 profit.

A "New Medical Office Employee" seminar was offered April 9 in Oklahoma City and April 10 in Tulsa, each attracting about 25 individuals.

The last two seminars scheduled for fiscal year 1985-86 are on the subject of "Estate Planning for Physicians" and are scheduled for Saturday, April 26, in Oklahoma City and May 3 in Tulsa.

The Council has already authorized the sponsorship of three additional seminars or workshops in 1986: A second Office Management series to be scheduled for early fall, a Workers' Compensation Workshop to be scheduled as soon after the end of the Legislative session as possible in order to update physicians on the changes, and a Computers in Medical Office seminar or workshop coupled with exhibits to be scheduled at some convenient time during late summer or early fall.

*D. Underwriting Review* — The most important function carried out by the Council on Member Services this administrative year has been the continued conduct of the annual underwriting review for the Association-owned Physicians Liability Insurance Company (PLICO).

The Underwriting Plan for PLICO requires that each year the Association's Council on Member Services review all claims, settlements, or judgments to determine whether or not there is a pattern of losses that could be prevented through the underwriting or loss prevention mechanism.

In addition, the Council conducted individual reviews on problem cases or to resolve underwriting difficulties whenever a physician would apply for coverage and there appeared to be an underwriting problem in the application.

For its own internal functioning, the Council unanimously adopted a rule stating that if the Council is to consider an appeal of an underwriting decision, it must have a waiver of the right to access information signed by the physician. Further, if that waiver is altered or amended in any way, the appeal process will stop immediately.

**E. Sponsored Tours** — Intrav is one of the most respected tour operators in the world. The OSMA has utilized the Intrav Corporation for sponsored tours for many years and is extremely well satisfied with the company's professionalism. It works primarily with professional associations representing medical doctors, bankers, lawyers, CPAs, etc.

The OSMA recovers all of its expenses for promoting tours from Intrav Corporation and is therefore able to make them available to physician members at no cost to the Association. One of the interesting things about the Intrav tours is that they are made up from several different states and usually contain an excellent cross-section of other professionals.

In 1985-86, the Association sponsored or is sponsoring the following tours:

#### 1985

China/Yangtze River (August)  
Russia (September)  
Virgin Islands (December)

#### 1986

South America (January)  
East Africa (January)  
Western Caribbean (March)  
Spain (April)  
Alaska/Canada (June)  
Swiss Tyrolean Alps (June)  
Switzerland/Germany (June)  
Scandinavia/Leningrad (July)  
Canada/New England (September)

Respectfully submitted,  
William O. Coleman, MD  
Chairman  
Council on Member Services

#### Attachment 1 Group Term Life

The OSMA Group Term Life program offers coverage from \$25,000 to \$300,000 for the physician and his spouse, and from \$10,000 to \$100,000 for the employee of a physician. The Accidental Death benefit is available up to \$100,000 under the Group Term Life program. The combination of these gives a maximum of \$200,000 Accidental Death benefit available under the Oklahoma State Medical Association's program.

Dependent coverage is available at \$2.00 per year for coverage up to \$2,000 for children at home. This \$2.00 per year covers all children regardless of how many children are in the family.

After a physician has been in the program for one year, he or she is eligible to convert to an Ordinary Life policy through Loyalty Life Insurance Company. We have received a manual and conversion applications from Loyalty Life and find their rates very competitive for these older ages.

We have established a pending system and contact physicians within a few months of the billing and of their birthday changes at 60, 65, and 68 to prevent the loss of coverage in cases where it is truly needed to be maintained after a physician has retired.

	1983	1984	1985
Written Premiums	\$63,460.00	\$90,097.00	\$83,503.00
Losses Incurred	-0-	-0-	25,000.00

The program had approximately 6 million dollars in face amount when we assumed marketing responsibility. Today it covers 350 people for over 20 million dollars in total face amount.

#### GXM-X Disability Income

At this time we have 397 lives on this program. Each six months we drop those physicians who have turned 70 years of age.

Experience is as follows:

	1982	1983	1984	1985
Written Premiums	\$161,612	\$166,262	\$178,495	\$205,779
Incurred Losses	67,017	* -0-	83,072	119,540
Ratio	41.5%	* -0-	46.5%	58%

\*due to release of claim reserve

There are three benefit levels within the program. All begin the benefit period with the first day of an accident and eighth day of sickness.

**Plan L-65** — Accident benefits payable for lifetime. Sickness benefits payable to age 65 or for a two-year maximum period if the disability begins between the 63rd and 70th birthdays. Benefits are payable based on being unable to perform the substantial and material duties of your regular occupation.

**Plan L-7** — Accident benefits payable for lifetime. Sickness benefits payable for a 7-year maximum period, but not beyond age 65; for a two-year maximum period if disability begins between the 63rd and 70th birthdays. Benefits are payable based on being unable to perform the substantial and material duties of your regular occupation.

**Plan 5-2** — Accident benefits payable for a 5-year maximum period. Sickness benefits payable for a 2-year maximum period. Benefits payable based on being unable to perform the substantial and material duties of your occupation.

The waiting period may be extended, which in turn reduces the premiums.

Included as additional features are:

1. \$1,000 Accidental Death Benefit
2. Pays 100 to 200 times the selected weekly indemnity for accidental loss of limbs, sight, speech, and hearing as scheduled in the policy.
3. Covers physicians fees for treatment for non-disabling injuries, to a maximum of the amount of one week's indemnity provided no other indemnity is payable for such injury under the policy.
4. Premium payments will be suspended, while the policy is in force and prior to age 60, after you receive total disability benefits for six continuous months. Waiver of Premiums continues as long as you continue to receive benefits.
5. Pays a minimum lump sum amount for specific fractures and dislocations.
6. Benefits are payable regardless of other insurance.

Options under this program are:

1. **Cost of Living Increase** — This new feature is automatically added to all newly issued policies for applicants under age 45 who have fully satisfied the Company's underwriting requirements. It can add approximately 10% to your monthly benefits each year until your monthly benefits reach the option maximum of \$4,000.00. You may exercise such option without further underwriting at any of the anniversary dates prior to age 50. You will be notified of its availability on each of the anniversary dates and also of the premium charge for the increase available. You may accept or reject the offer as you see fit.



**During the Trauma Services section of the Scientific Program, Roger A. Siemens, MD, talks about "Special Problem Areas." Dr Siemens is a clinical associate professor of surgery at OU's Tulsa Medical College.**

2. **Optional Recovery Benefit Rider** — Once you return to work on a full or part-time basis, and no longer qualify for regular weekly indemnity benefits, the Company will pay a lump sum benefit equivalent from ¼ to 3 months disability payments, depending on the length of your disability as per the schedule:

If your disability for which indemnity is payable lasted at least	Benefit Payable
45 days	¼ months benefit
3 months	¾ months benefit
9 months	2¼ months benefit
12 months	3 months benefit*

3. **Residual Disability Benefit** — Residual Disability is a condition whereby: (1) You are unable to perform one or more of the substantial and material duties of your occupation; or (2) are unable to perform all of the substantial and material duties of your occupation for as much time as is normally required. (3) You are not totally disabled. (4) You are under the care of a duly licensed physician, other than yourself, and (5) you suffer a continuous loss of at least 20% of your prior monthly income.

The qualifying period is the period of total and/or residual disability which must precede payment of residual disability benefits. The qualifying period must include 30 days of continuous total disability. If your policy waiting period is 30 days or less, you must select the 30-day qualification period. If your policy waiting period is 90 days, you must select the 90-day qualification period. If your policy waiting period is 180 days, you must select the 180-day qualification period.

The combined period for which either total or residual disability benefits are payable is equal to your maximum benefit period for total disability, subject only to the following conditions: (1) In no event will residual disability benefits be payable beyond age 65. (2) The first six monthly residual disability payments will never be less than 50% of the monthly benefit for total disability.

The following formula is used to determine the residual disability benefit:

$$\frac{\text{Loss of Monthly Income}}{\text{Prior Monthly Income}} \times \text{Monthly Benefit for Total Disability} = \text{Residual Disability Benefit}$$

Limits under this policy are \$5,000 a month.

Limits for Accidental Death and Dismemberment available up to \$100,000 under this policy.

#### Hospital Indemnity

Pays a specified amount per day that an insured is a patient in a hospital. This program will pay up to 365 days benefit from \$20.00 to \$200.00 per day. It can include the member, his spouse, and family. The policy does not coordinate with any other health insurance you may have, i.e., the money comes directly to you for each day of hospitalization. You could use it to pay a yardman, a housekeeper, babysitter, or to meet your deductible and co-insurance responsibilities under your group health plan. The policy is not underwritten (no health questions). It, however, provides no benefit for the first 24 months of the policy for any health problems treated in the 12 months before the policy's effective date.

There are 159 lives on this program.

Experience is as follows:

	1982	1983	1984	1985
Written Premiums	\$15,185	\$14,349	\$14,418	\$17,455
Incurred	4,903	3,020	1,660	11,620

#### Accidental Death and Dismemberment

This program provides benefits from \$25,000 to \$100,000 for accidental loss of life and a portion thereof for accidental loss of limb, eyesight, speech, or hearing.

It provides 24 hour protection wherever you go.

There are 211 lives on this program.

	1982	1983	1984	1985
Written Premiums	\$6,944	\$ 6,392	\$ 6,137	\$ 5,862
Incurred Losses	-0-	25,000	25,000	-0-
Loss		391.1%	407.9%	-0-

#### Office Overhead Expense Program

Physicians see sick and injured people every day. Some of these people are disabled, needing time to heal.

But healing time is costly time. Many suffer the side effects of financial hardship from their loss of earned income.

For self-employed professionals, such as physicians, healing time creates even more disorders. Not only has the income ceased, but overhead expenses continue. Rent, utility, and payroll expenses must still be met even though earnings have ceased. These expenses might be met from savings. Paying overhead for a month or two is one thing, but suppose the physician is disabled for a year or more? Why should long-term financial plans be disrupted when it's not necessary?

Prevent this financially debilitating situation with the Open Door policy. If you are totally disabled by either sickness or injury, the remedy pays benefits to cover up to 100% of your office overhead expenses.

This plan features:

**Big Benefits** — You choose your benefits to fit your needs — benefits are available in \$100 increments up to \$5,000 a month maximum.

**Lingering Coverage** — You receive benefits while you are totally disabled, up to 18 months.

**Tax Relief** — Premiums paid for the Open Door policy are generally a tax-deductible business expense. Benefits used to pay overhead are generally tax deductible.

**Flexibility** — You choose when payments start: either 15 days or 30 days after disability begins.

There are 239 lives on this program.

Experience is as follows:

	1982	1983	1984	1985
Written Premiums	\$51,540.31	\$62,325.48	\$80,243.28	\$89,986.95
Paid Claims	4,446.66	2,350.00	10,500.00	3,483.33
Loss Ratio	17.4%	14.5%	11.5%	11.1%

## OSMA-Sponsored Personal Umbrella Liability Program

The OSMA Personal Umbrella Liability Program was discontinued effective February 1, 1986. The U.S. Fire Insurance Company which had provided this program since 1977 withdrew all mass market programs of this type nationwide. Because of the constricted insurance marketplace we were unable to find a replacement carrier willing to write a similar program.

Fortunately, where we wrote the other lines of insurance, such as the homeowners or automobile coverage, we were able to renew a substantial number of physicians' Personal Umbrellas.

Market conditions seem to be improving and we are negotiating with the companies for a replacement program for next year.

OSMA Experience Continental Insurance Company			
	Premiums Earned	Losses Incurred	Ratio
<b>Disability Income</b>			
1985	\$205,779	\$119,540	58
1984	178,495	83,072	46
1983	166,262	0*	0*
1982	161,612	67,017	41
1981	135,017	191,251	142
*due to release of reserve			
<b>Hospital Indemnity</b>			
1985	17,455	11,620	67
1984	14,418	1,660	11
1983	14,349	3,020	21
1982	15,185	4,903	32
1981	12,922	9,940	77
<b>AD&amp;D</b>			
1985	5,862	0	0
1984	6,137	25,000	408
1983	6,392	25,000	391
1982	6,944	0	0
1981	6,414	0	0

OSMA Experience Combined Insurance Company			
	Written Premiums	Paid Claims	Ratio
<b>Business Overhead</b>			
1985	89,986.95	3,483.33	11.1
1984	80,243.28	10,500.00	11.5
1983	62,235.48	2,350.00	14.5
1982	51,540.31	4,446.66	17.4
1981	42,219.45	1,500.00	

## Report of the OKLAHOMA MEDICAL POLITICAL ACTION COMMITTEE

### Subject: Annual Report

Presented by: Larry L. Long, MD, Chairman

Referred to: Reference Committee III

### Introduction

The Oklahoma Medical Political Action Committee is a voluntary, unincorporated entity made up of individual physicians, spouses, and students interested in helping political candidates become elected to office. OMPAC is an independent and autonomous organization managed by a Board of Directors. The Board of Directors has control over the policies and activities of the Committee and serve without compensation. The OMPAC Board conducts the business of the Committee and otherwise meets several times during an election year to distribute OMPAC funds to candidates.

### Review of Activities

The Oklahoma Medical Political Action Committee is pleased to report some very positive changes in virtually every aspect of the Committee. The time and money donated by our physicians is the underlining key to the success OMPAC is now experiencing.

During the AMA House of Delegates Interim Meeting in Washington, DC, OMPAC was recognized on the floor of the House of Delegates as one of ten political action committees having increased its membership over previous years. The membership increase has been noted by other state society PACs as well as the American Medical Political Action Committee. The OMPAC Board of Directors credits this increase in membership to the growing political awareness of Oklahoma physicians, spouses, and students throughout the state.

1986 is the 25th Anniversary of AMPAC and during this Silver Anniversary year OMPAC is continuing to make every effort to promote the physician's interest on the federal and state governmental levels. As 1986 is also an election year, the need for increased membership in the PAC and for even greater political awareness should increase significantly!

In the latter part of 1985, I appointed an Executive Committee to the OMPAC Board of Directors. The primary purpose of this Executive Committee was to establish Congressional Directors to promote the PAC philosophy and increase contributions and member support. The OMPAC Executive Committee set the following goals for the 1986 election year:

1. To increase OMPAC membership above the 1,000 member mark.
2. To urge physicians' spouses to join OMPAC.
3. To raise \$100,000.00 for political action contributions. Approximately \$70,000-\$80,000 going to state races and support of tort reform.
4. To explore the possibility of establishing a resident/student membership program.

The following OMPAC financial/membership figures will reflect the success of the above-mentioned goals:



Waiters arrive with the sparkling conclusion to Friday night's Inaugural Dinner — a dessert of baked Alaska.

#### OMPAC financial report as of April 18, 1986

OMPAC contribution account	\$63,665.18
Auxiliary membership	155
Resident/student membership	27
Regular Member (\$50.00)	716
Sustaining Member (\$100.00)	129
"200 Club" Member (\$200.00)	60
Total Membership 1986	1,087

(The previous all time OMPAC membership record established in 1985 was 783.)

The success of the Auxiliary OMPAC membership drive is reflected in the figures below:

Auxiliary \$10 membership	84
Auxiliary \$30 membership	43
Auxiliary \$50 membership	18
Auxiliary \$100 membership	5
Auxiliary \$200 membership	5
Total Auxiliary	155

(These membership figures are included in the overall OMPAC membership figures listed above.)

While contribution totals to OMPAC are very important, the OMPAC Board of Directors and its Executive Committee would like to stress that membership in OMPAC, thus bringing greater political awareness in our profession, is our ultimate goal. It should also be noted that while the present OMPAC contribution total may appear low, it is the obligation of OMPAC to pass on contributions to AMPAC in an orderly fashion. The amount of OMPAC contributions delivered to AMPAC as of this date is \$23,110.00.

#### Recommendations

The Oklahoma Medical Political Action Committee will continue to strive for excellence in every aspect of political action. OMPAC will continue to strive for even greater membership and contribution goals.

For contribution purposes, the OMPAC Board of Directors is scheduled to meet in late May, 1986.

Respectfully submitted,  
Larry L. Long, MD, Chairman

### Report of the PHYSICIAN RECOVERY COMMITTEE

#### Subject: Annual Report

Presented by: Ted Clemens, Jr., MD, Chairman

Referred to: Reference Committee III

The Physician Recovery Committee is once again pleased to report significant progress.

Currently the Committee is actively working with 100 physicians (an increase of 70 over last year) as they undergo initial intervention and treatment, monitoring, follow-up and support during the first year of their recoveries.

The Physician Recovery Hotline telephone number is published monthly in the JOURNAL of the OSMA and the OSMA News.



J. Darrel Smith, MD, the program director, has spoken to medical student groups in Oklahoma City and Tulsa, and to county medical societies and auxiliary groups.

The presentation used by the Physician Recovery Committee includes some very informative and dramatic audiovisual materials. The Committee would strongly urge all county societies and their auxiliaries and hospital medical staffs to include a presentation by the Physician Recovery Committee on their meeting schedules this year.

The Committee has produced an informational brochure, currently being printed, which will be distributed to OSMA members and included in the material received by new members.

The Committee has received favorable treatment from both print and broadcast media in Oklahoma City and Tulsa through several newspaper articles, television news stories, and appearances on public service programs. The Committee feels this publicity serves several useful purposes: 1) to assure the public that the profession is aware of and deals with the problem of chemical or alcohol dependency; 2) that physicians care and are willing to assist colleagues in need; and 3) the extraordinarily high recovery rate for physicians — about 90 percent successful — can serve as a model for others with dependency problems.

The Committee, on occasion, has received and responded to requests for assistance from the Oklahoma Osteopathic Association. The Committee will continue to work with the OOA and encourage that Association to provide an equitable share of financing for the Committee.

Finally, it must be noted that the relationship between the Physician Recovery Committee and the Oklahoma Board of Medical Examiners is excellent. The Board actively refers physicians under its jurisdiction to the Committee for treatment and recovery follow-up.

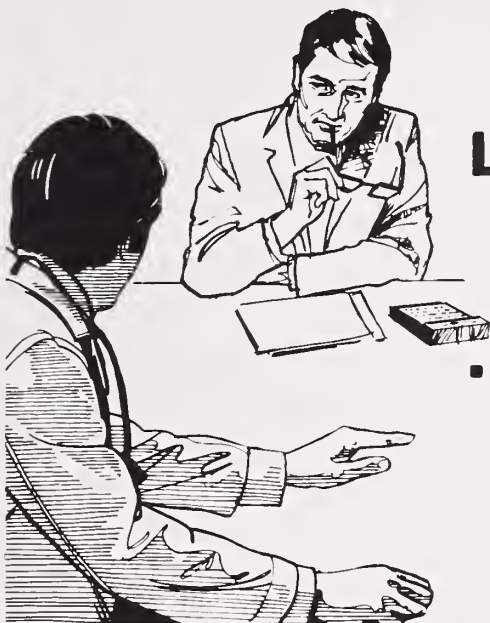
**“With the Grace of God — we will again meet together next year, members of a continued strong and most caring profession.”**

— N. L. Dunitz, MD  
OSMA President, 1986-87

The proposed budget submitted to the OSMA Board of Trustees for approval:

Program Director	
(physician, one-third time) . . . . .	\$40,000.00
Travel (in-state and professional meetings) . . . . .	4,500.00
Miscellaneous . . . . .	2,500.00
Dues . . . . .	100.00
Audiovisuals/books . . . . .	1,000.00
Clerical support . . . . .	1,000.00
Telephone hotline . . . . .	600.00
Total . . . . .	\$49,700.00

Respectfully submitted,  
 Ted Clemens, Jr., MD, Chairman  
 J. Darrel Smith, MD, Program Director  
 Homer V. Archer, MD  
 Macaran Baird, MD  
 Luis A. Barrios, MD  
 Theodore J. Brickner, Jr., MD  
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## THE LAST WORD

■ **Several lucky physicians left this year's OSMA Annual Meeting** with a little more than they had planned on. Prize drawings were held in the Exhibit Hall and four lucky doctors came up winners. J. R. Parmar, MD, Eufaula, won the grand prize, a vacation to Florida's Disneyworld, compliments of American Airlines, Vistana Resort (Kissimmee, Fla), and Prime Time Travel (Oklahoma City and Edmond). Stephen Tkach, MD, Oklahoma City, won an NEC videotape recorder, and Elvin M. Amen, MD, Bartlesville, won a color television. Thomas M. Story, MD, Sand Springs, won the \$100 cash prize offered by the Oklahoma Lung Function Laboratory of Oklahoma City.

■ **The OSMA sponsored golf and tennis tournaments** in conjunction with May's Annual Meeting in Tulsa. Winners in golf were: Low Gross — First Place, Ray C. Babb, Jr., MD, Tulsa; Low Gross — Second Place, Leon D. Combs, MD, Shawnee; Low Gross — Third Place, George H. Ladd, MD, Muskogee. In the competition for Low Net, the first, second, and third place winners, respectively, were: Timothy H. Dennehy, MD, Tulsa; Stone M. Hallquist, MD, Tulsa; and Jesse S. Chandler, MD, Muskogee. At press time, due to weather and scheduling problems, the winners of the tennis tournament had not been determined.

■ **Selective use of nasogastric tubes and abdominal drains**, along with prompt postoperative feeding, leads to shorter hospital stays for patients undergoing gallstone surgery, suggests a study reported in the June *Archives of Surgery*. Gregory K. Luna, MD, and colleagues, of the University of Washington School of Medicine, Seattle, compared length of stay for 200 patients operated on for gallstone disease at two community hospitals. "Cumulative hospitalization was 517 days shorter at one institution," the researchers say, representing a savings of approximately \$129,250. "Gastric intubation prolongs the time to institution of postoperative feedings, and, ultimately, to patient discharge," they observe.

■ **The Aetna Medicare office in Oklahoma City** has informed the OSMA that physicians needing additional Medicare claim forms may obtain them by contacting DDW Printing in Oklahoma City at (405) 787-0622 or by writing to DDW Printing at 430 North Rockwell, Oklahoma City, OK 73127.

■ **A pertussis (whooping cough) epidemic** involving 351 children during calendar year 1983 in Oklahoma is described in the May *American Journal of Diseases of Children*. Benjamin M. Nkowane, MD, of the Centers for Disease Control in Atlanta, and colleagues report that 77 of the patients were hospitalized, and that 47 contracted pneumonia. Three children experienced seizures, three were diagnosed as having encephalopathy, and at one year follow-up one patient had persistent seizures. "Aggressive control of the outbreak was attempted in Oklahoma City," the researchers say. "However, the effort failed to immunize 82 percent of the 931 children in the initial target group." Commenting editorially, James D. Cherry, MD, MSc, says the epidemic signals an ominous future for pertussis, since vaccine numbers have dropped dramatically during the past four years.

■ **Magnetic resonance imaging (MRI)** accurately identified the organ of origin of tumor masses and differentiated soft tissue from fat, fluid or hemorrhage in a study involving 139 children reported in the May *Archives of Surgery*. Mervyn D. Cohen, MB, ChB, of Indiana University School of Medicine in Indianapolis, and colleagues say MRI was better than computed tomography in defining size and extent of soft-tissue tumor masses and was accurate in defining spread of bone sarcomas in bone marrow and in defining invasion of major abdominal blood vessels by Wilms' tumors. "As a means of evaluating pediatric neoplasms, MRI is noninvasive, painless and well tolerated by children, and it uses no radiation," the researchers state.

■ **Roy L. DeHart, MD, Oklahoma City**, professor and director, Division of Occupational Medicine, Department of Family Practice, at the University of Oklahoma Health Sciences Center has received the Theodore C. Lystar Award for outstanding achievement in the general field of aerospace medicine. Dr DeHart was given the award in recognition for his work on the new textbook *Fundamentals of Aerospace Medicine*, which he edited and helped write. The Aerospace Medical Association calls the book "the authoritative textbook today in the field." □

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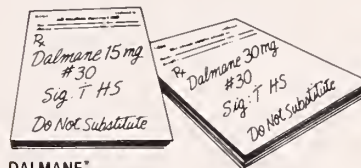
The recommended dose in elderly or debilitated patients is 15 mg. Contraindicated in pregnancy.

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**References:** 1. Kales J, et al: *Clin Pharmacol Ther* 12:691-697, Jul-Aug 1971. 2. Kales A, et al: *Clin Pharmacol Ther* 18:356-363, Sep 1975. 3. Kales A, et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 4. Kales A, et al: *Clin Pharmacol Ther* 32:781-788, Dec 1982. 5. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 6. Dement WC, et al: *Behav Med*, pp 25-31, Oct 1978. 7. Kales A, Kales JD: *J Clin Psychopharmacol* 3:140-150, Apr 1983. 8. Tennant FS, et al: Symposium on the Treatment of Sleep Disorders, Teleconference, Oct 16, 1984. 9. Greenblatt DJ, Allen MD, Shader RI: *Clin Pharmacol Ther* 21:355-361, Mar 1977.



**DALMANE**<sup>®</sup>  
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Before prescribing, please consult complete product information, a summary of which follows:

**Indications:** Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening, in patients with recurring insomnia or poor sleeping habits, in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

**Contraindications:** Known hypersensitivity to flurazepam HCl, pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patients to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

**Warnings:** Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Withdrawal symptoms rarely reported, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

**Precautions:** In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

**Adverse Reactions:** Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase, and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

**Dosage:** Individualize for maximum beneficial effect. Adults: 30 mg usual dosage, 15 mg may suffice in some patients. Elderly or debilitated patients: 15 mg recommended initially until response is determined.

**Supplied:** Capsules containing 15 mg or 30 mg flurazepam HCl.

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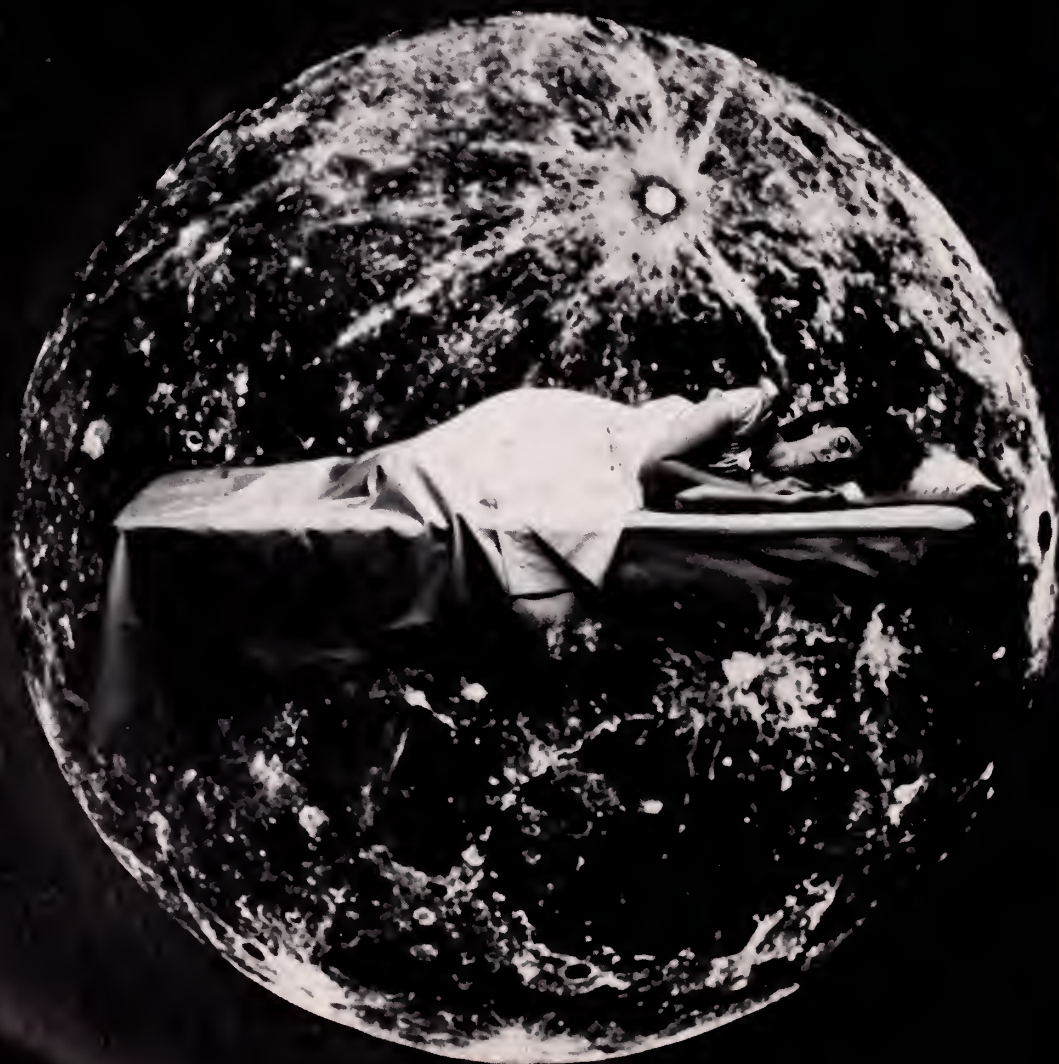
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Please see preceding page for summary of product information.

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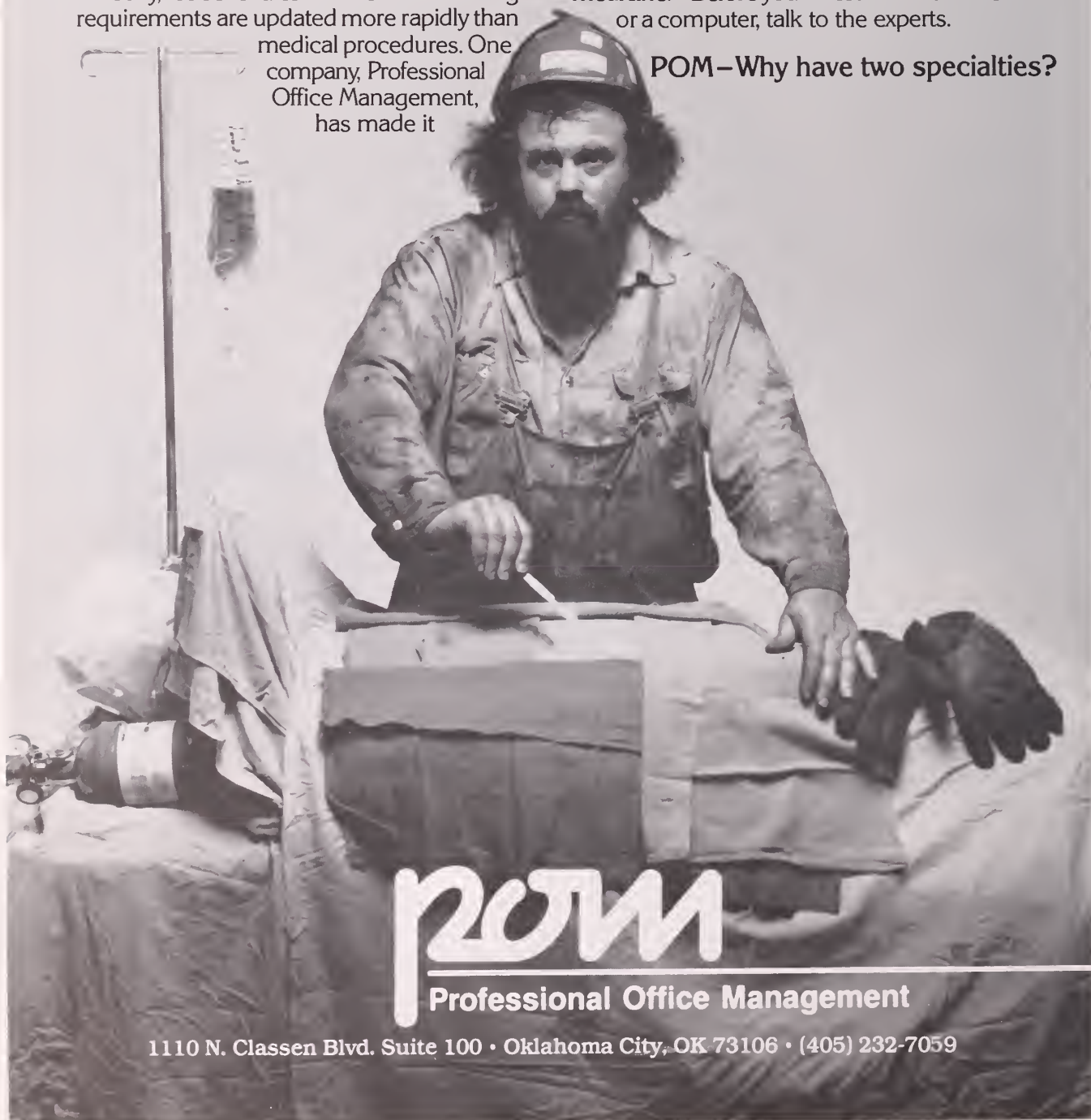
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OKLAHOMA STATE MEDICAL ASSOCIATION

AUGUST 1986

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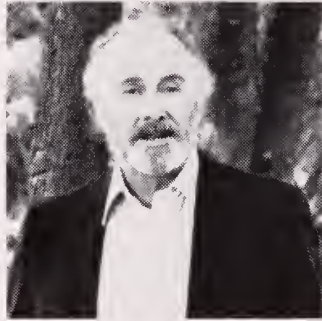
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***Controls nocturnal acid  
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***Heals active duodenal ulcers after 4 weeks  
in most patients\*<sup>1</sup>***

ZANTAC 300 mg h.s.	270/320	84%
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*In well-controlled, double-blind, multicenter trials, ZANTAC 300 mg h.s. healed active duodenal ulcers in 84% of patients after 4 weeks. After 8 weeks, healing rates may be higher with ZANTAC 150 mg b.i.d. (92%) than with ZANTAC 300 mg h.s. (87%).*

***Relieves pain and other symptoms as effectively  
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# **Zantac<sup>®</sup>300**



*ranitidine HCl/Glaxo 300 mg tablets*

***Once-daily dosing may enhance compliance in patients for whom dosing convenience is important***

***Side-effects profile comparable to ZANTAC 150 mg b.i.d.<sup>1-3</sup>***

*Headache—sometimes severe—has been reported. Rare effects on the CNS, cardiovascular, GI, hepatic, and integumental systems have been observed, as well as rare cases of hypersensitivity reactions. See ADVERSE REACTIONS section of Brief Summary of Product Information before prescribing.*

***No significant interference with the hepatic cytochrome P-450 enzyme system at recommended doses***

*ZANTAC 300 mg h.s. had no significant drug interactions with theophylline or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications which decrease gastric acidity are administered.*



**Glaxo** / 

*See next page for references and Brief Summary of Product Information.*

*\*It is not known exactly how much acid inhibition is needed to heal ulcers.*

# IN ACTIVE DUODENAL ULCERS

## Once-a-night h.s. therapy controls acid rain

**Zantac<sup>300</sup>**  
ranitidine HCl/Glaxo 300 mg tablets

**References:** 1. Data available on request, Glaxo Inc. 2. Ireland A, Colin-Jones DG, Gear P, et al: Ranitidine 150 mg twice daily vs 300 mg nightly in treatment of duodenal ulcers. *Lancet* 1984;2:274-275. 3. Colin-Jones DG, Ireland A, Gear P, et al: Reducing overnight secretion of acid to heal duodenal ulcers. *Am J Med* 1984; 77 (suppl 5B):116-122.

**ZANTAC<sup>®</sup> 150 Tablets**  
(ranitidine hydrochloride)  
**ZANTAC<sup>®</sup> 300 Tablets**  
(ranitidine hydrochloride)

### BRIEF SUMMARY OF PRODUCT INFORMATION

#### INDICATIONS AND USAGE: ZANTAC<sup>®</sup> is indicated in:

1. Short-term treatment of active duodenal ulcer. Most patients heal within four weeks. Studies available to date have not assessed the safety of ranitidine in uncomplicated duodenal ulcer for periods of more than eight weeks.
2. Maintenance therapy for duodenal ulcer patients at reduced dosage after healing of acute ulcers. No placebo-controlled comparative studies have been carried out for periods of longer than one year.
3. The treatment of pathological hypersecretory conditions (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of active, benign gastric ulcer. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated. Studies available to date have not assessed the safety of ranitidine in uncomplicated, benign gastric ulcer for periods of more than six weeks.
5. Treatment of gastroesophageal reflux disease. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer; active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

**CONTRAINDICATIONS:** ZANTAC<sup>®</sup> is contraindicated for patients known to have hypersensitivity to the drug.

**PRECAUTIONS: General:** 1. Symptomatic response to ZANTAC<sup>®</sup> therapy does not preclude the presence of gastric malignancy.

2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function (see **DOSE AND ADMINISTRATION**). Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

**Laboratory Tests:** False-positive tests for urine protein with Multistix<sup>®</sup> may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

**Drug Interactions:** Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella*, *E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

**Pregnancy: Teratogenic Effects: Pregnancy Category B:** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Use in Elderly Patients:** Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

**ADVERSE REACTIONS:** The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC<sup>®</sup>. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

**Central Nervous System:** Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

**Cardiovascular:** Rare reports of tachycardia, bradycardia, and premature ventricular beats.

**Gastrointestinal:** Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

**Hepatic:** In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

**Musculoskeletal:** Rare reports of arthralgias.

**Hematologic:** Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

**Endocrine:** Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

**Integumental:** Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

**Other:** Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

**OVERDOSAGE:** There is no experience to date with deliberate overdosage. The usual measures to remove unabsorbed material from the gastrointestinal tract, clinical monitoring, and supportive therapy should be employed.

Studies in dogs receiving doses of ZANTAC<sup>®</sup> in excess of 225 mg/kg/day have shown muscular tremors, vomiting, and rapid respiration. Single oral doses of 1,000 mg/kg in mice and rats were not lethal. Intravenous LD<sub>50</sub> values in rat and mouse were 83 and 77 mg/kg, respectively.

**DOSE AND ADMINISTRATION: Dosage Adjustment for Patients with Impaired Renal Function:** On the basis of experience with a group of subjects with severely impaired renal function treated with ZANTAC<sup>®</sup>, the recommended dosage in patients with a creatinine clearance less than 50 ml/min is 150 mg every 24 hours. Should the patient's condition require, the frequency of dosing may be increased to every 12 hours or even further with caution. Hemodialysis reduces the level of circulating ranitidine. Ideally, the dosage schedule should be adjusted so that the timing of a scheduled dose coincides with the end of hemodialysis.

**HOW SUPPLIED:** ZANTAC<sup>®</sup> 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

ZANTAC<sup>®</sup> 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

Store between 15° and 30° C (59° and 86° F) in a dry place. Protect from light. Replace cap securely after each opening.

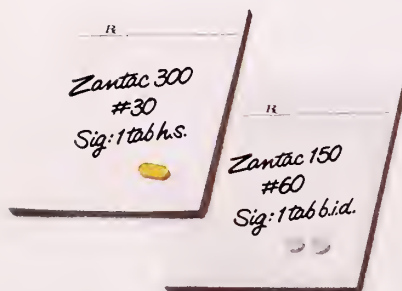
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June 1986

**Glaxo**

Glaxo Inc.  
Research Triangle Park, NC 27709

Now...two effective regimens to treat active duodenal ulcers



Before prescribing, see complete prescribing information in SK&F CO. literature or *PDR*. The following is a brief summary.

**\* WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum  $K^+$  levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict  $K^+$  intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other anti-hypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

**Supplied:** 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

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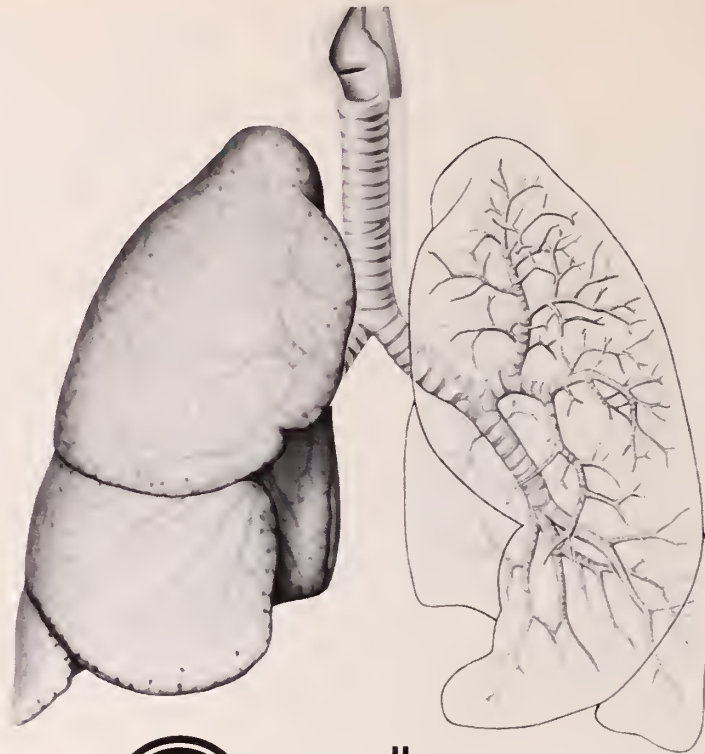
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**Note:** Ceclor<sup>®</sup> is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

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**Indications:** Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

**Contraindications:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in differential diagnosis of antibiotic-

associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

#### **Precautions:**

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and infants less than one month old. Ceclor

penetrates mother's milk. Exercise caution in prescribing for these patients.

#### **Adverse Reactions:** (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:


- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

#### **Abnormalities in laboratory results of uncertain etiology**

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly)

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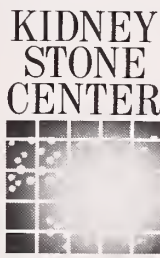
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## Ten Questions

This bit of news deserves your undivided attention and your most critical analysis. It concerns such hallowed institutions as individual rights, personal freedom, and the lawful autonomy of state governments.

A Boston federal court judge upheld the Massachusetts law which, since April 20, 1986, has compelled that state's physicians to accept Medicare assignments or lose their licenses to practice in Massachusetts.

The outcome of the almost certain appeal to the Supreme Court of the United States will determine, eventually, whether

- The authority to license doctors of medicine will remain in the hands of truly free men and women carrying out nonpolitical missions or will be turned over to demagogues and vote scavengers

- Licensing agencies in this country can withhold their sanctions until those under their jurisdiction sign a specified contract, even though such contract is unilateral, non-negotiable, and totally antithetic to the best interests of the prospective licensee

- Professional peers will continue to be involved in any aspect of the licensing process

- The right to practice medicine in this nation will be determined by anonymous bureaucrats in Washington, DC.

Such an impossible nightmare is a cold reality in Massachusetts today. Believe it . . . and ask yourself some questions.

If you were practicing medicine in a state with such a law, would you try to move to another state?

If you were a member of a licensing board which mandated personally executed contracts with federal agencies as a condition of licensure, would you resign your position?

If a state legislature can coerce a prospective licensee to sign a contract with a federal agency, can't the same legislature demand that the applicant sign contracts with private insurance companies, rental agencies, automobile dealers, and medical supply houses?

If a state legislature can demand these things of applicants for medical licensure, can't they demand the same of applicants for drivers' licenses, automobile licenses, and real estate licenses?

If a state requires that physicians sign contracts with Medicare before they are allowed to practice medicine in that jurisdiction, wouldn't it be reasonable that medical students be required to sign a letter of intent prior to their admission to medical schools in that jurisdiction?

If physicians are entitled to such singular licensing restrictions, why aren't accountants and engineers and lawyers?

If Medicare payments should be reduced by fifty or sixty or seventy-five percent, how will the physician whose license to practice medicine is contingent on his acceptance of such amounts make a living, pay his rent, or keep his office open?

If the Supreme Court upholds the decision of the federal judge in the Massachusetts Medicare mandate law, what will you do?

If such a law is tolerated by the public and sustained by the Supreme Court, isn't it likely that another law, telling us which patients we *must* accept, will be immediately forthcoming?

If this isn't enough to get your attention, to elicit some response, to create some visible reaction from you, what will it take?

—MRJ

As the summer winds down, it is once again being brought home to us the dangers and the creeping malignancy that exist when third parties, particularly the government, become involved in delivery of medical care to the people.

I am talking specifically of our relationship here in Oklahoma with our government and Congress, who, through their executive arm, the Health Care Financing Administration (HCFA), are in the process of trying to further penalize patients, and in many instances injure them directly, through pressures upon the physicians.

HCFA has recently informed our state peer review organization, which although possibly distasteful to many is at least under the direction of local physicians, that it will not renew the contract with our PRO in its present form. It has become obvious that HCFA wants more sanctions placed upon physicians. It would like public demonstrations and punishments directed toward the doctors of our state, and more and greater services denied and taken away from the patient population.

We have tried to cooperate with the tenets of HCFA and the congressional restraints on health delivery. We have been successful beyond anticipation in squeezing out most of the waste and inefficiencies that may have taken place in the past in health delivery. There may be a few spots which are still inadequate, but in general, our state PRO has received high accolades and acclaim from all governmental investigative bodies.



However, all this does not satisfy the insatiable appetite of HCFA. As always when government interferes, it wants more and more. You should know that your officers and leadership of the Oklahoma State Medical Association have taken the position with which I am sure you are in agreement, that ENOUGH IS ENOUGH! We will not be a partner to a program that is doomed to injure our patients, withhold necessary services from them, increase their risk of diminished health and well-being, and ultimately destroy the benefits that medical science has given to people throughout our state. It may be that some third party under the direction of HCFA and our Congress will take over the PRO function and impose upon us the sanctions which they desire. If so, we will fight them with every means we have available to us and will refuse to allow any insensitive bureaucracy to dictate unfair, unjust, and injurious methods of treating our patients.

It is true we may not succeed in these efforts, but we will certainly not be a voluntary party to the harm that our Congress appears willing to impose upon our patients, the people of Oklahoma.

A handwritten signature in dark ink. The signature is written in a cursive style and reads "Norman L. Dunitz, MD." The letters are fluid and connected, with a prominent "N" and "D".

Norman L. Dunitz, MD

# Endoscopic Laser Therapy for Gastrointestinal Disorders

## Part IV: Laser Therapy in Neoplastic Disease, Continued (Last of four parts)

MARK H. MELLOW, MD

**This, the final installment on the uses of laser therapy in gastrointestinal disorders, focuses on the treatment of colorectal neoplasia and discusses the future of laser technology in surgery.**

### Colorectal Neoplasia

Carcinoma of the colon and rectum ranks second to lung cancer as the most common malignant neoplasm in the United States today. Despite gains in screening techniques (eg, stool occult blood testing, air contrast barium enema, fiberoptic colonoscopy), many patients have advanced disease at time of diagnosis. In patients with liver, lung, and/or intra-abdominal metastases, median survival is disappointingly short — in the range of five to nine months in most reported series. Surgery has been the mainstay of treatment for this illness and the rationale for surgery is sound for (1) relief and/or prevention of intraluminal obstruction, (2) prevention and/or treatment of bleeding, and (3) “debulking” of tumor mass.

In patients whose life spans are limited and in whom the role of surgery is purely palliative and in patients who are elderly or who have serious associated medical conditions that affect the morbidity

and mortality of an operative approach, nonsurgical treatment would certainly be desirable. Lesions involving the mid or distal rectum often require abdominoperineal (AP) resection with colostomy. Occasionally, even more proximal lesions require colostomy. The consequences of colostomy are often devastating both to the patient and the patient's family.

The impact of age on operative mortality in AP resection is sizable as well, rising from approximately 3% to 5% in patients under age 65 to approximately 20% to 30% in patients over the age of 80. Endoscopic laser therapy thus holds considerable potential in the nonoperative management of selected patients with colorectal neoplasia.

Lambert in France has performed by far the largest number of laser treatments in colorectal neoplasia, having treated over 500 patients thus far.<sup>1-3</sup> In the United States, experience is considerably more limited.<sup>4</sup> At Presbyterian Hospital in Oklahoma City we have had the opportunity thus far to treat 30 patients with colorectal neoplasms (Table 1). Rectal and distal colonic lesions comprise almost all of the treated cases for the following reasons: (1) Accessibility, (2) decreased chance of disastrous complications, and (3) less appealing treatment alternatives. Rectal neoplasms can be treated through a flexible or rigid sigmoidoscope. Patient preparation requires simply

Mark H. Mellow, MD, Division of Gastroenterology, Oklahoma City Clinic, 701 Northeast 10th Street, Oklahoma City, OK 73104.

**Table 1. Colorectal Neoplasms**  
(Presbyterian Hospital Experience Through 1/20/86)

<b>Age 57 - 85 (mean age 75)</b>	
<b>Lesions</b>	
CA	15
Villous adenomas	15
<b>Location</b>	
Rectum	23
Sigmoid	4
Right colon	3
<b>Indications</b>	
Obstruction	17
Bleeding	12
Avoid colostomy	15
Avoid surgery	11



**Fig 1a.** Distal margin of rectal carcinoma, prior to laser treatment. Note extensive polypoid mass with marked luminal narrowing.

a few cleansing enemas. Treating below the peritoneal reflection eliminates the problem of free intraperitoneal perforation (although local perforation and rectovaginal fistulae remain possible). Most importantly, however, surgical treatment of most rectal lesions still requires AP resection and colostomy.

Many of the patients treated thus far have had nonmalignant but extensive distal rectal neoplasms (villous adenomas). With this lesion, cures are attainable. In Lambert's series, two-thirds of his patients had no gross or microscopic evidence of residual lesions on endoscopic follow-up. In most patients, recurrence was small and easily retreated with the laser. Importantly, however, large villous adenomas often harbor carcinomas. The full tissue examination that usually follows surgery is not possible after laser treatment. Therefore, most physicians would not recommend routine use of the laser for ablation of suspected benign lesions unless colostomy is necessary for treatment and the patient refuses, or unless the patient's age and general medical condition make surgery a high-risk proposition. Since many patients with extensive villous adenomas of the rectum fall into one of these two categories, laser treatment has thus far proved to be an appealing alternative.

The technique of laser treatment of colorectal neoplasms is similar to that described previously for upper gastrointestinal neoplasms. The laser fiber is passed through the biopsy channel of an endoscope, and the beam is directed at the desired tissue site from a treatment distance of approximately half a centimeter. Treatments are performed on an every-other-day basis and are continued until, in the case of a noncircumferential rectal lesion, the visible neoplastic tissue has been destroyed. In circumferential lesions producing obstruction, laser treatment is con-

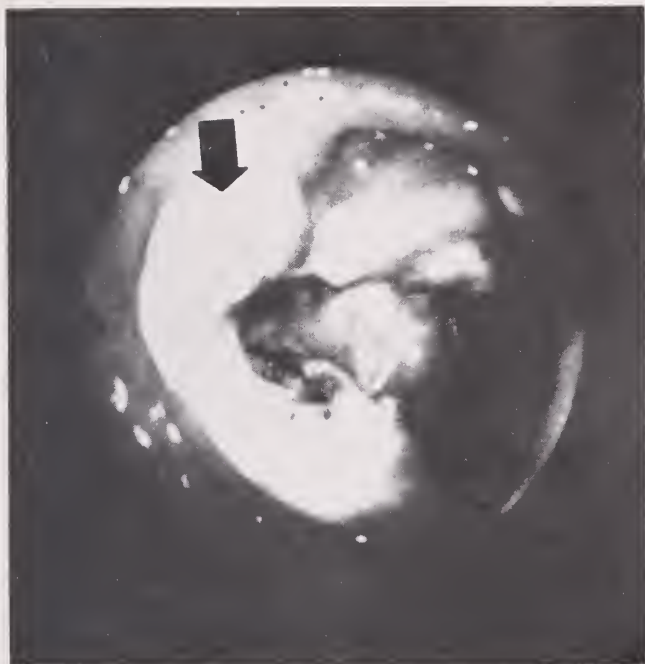
tinued until the endoscope can be easily passed beyond the previously obstructed segment. As with esophageal and esophagogastric neoplasms, treatments have been completed in a mean of three sessions (five days). Patients are seen for follow-up at intervals of four to eight weeks, depending upon initial tumor load and regrowth patterns. Data on our patients with rectal cancer are summarized in Table 2. Some brief illustrative cases follow.

### Case Number One

Patient NB is a 71-year-old man with severe coronary disease with angina and intermittent ventricular ectopy, even after coronary bypass surgery. He had, in fact, suffered a myocardial infarction after a colonoscopy preparation. He had an extensive villous adenoma of the rectum which had been biopsied and cauterized on several previous occasions. His chronic bleeding continued. On our initial examination, we found the lesion extended from the anal verge to 8 cm proximally and covered one-half of the circumference. Endoscopic laser therapy was undertaken. Follow-up at 8 weeks and 38 weeks revealed polypoid excrescences which were re-treated. On last visit, at 65 weeks, no gross or microscopic disease was discernible.

### Case Number Two

Patient DB was an 85-year-old man with extensive rectal cancer. He was found to have rectal cancer with a large pulmonary metastasis in September 1983. No treatment was undertaken. His bleeding and tenesmus continued and he was first seen at Presbyterian Hospital in March of 1983 with multiple pulmonary metastases and partially obstructing rectal cancer. Laser treatment was begun and



**Fig 1b.** During treatment. Note white "bloodless" coagulum found after initial treatment session. Because of the YAG laser's ability to obliterate blood vessels, patients usually experience rapid decrease in bleeding even though tumor debulking is not yet completed.



**Fig 1c.** Prior to final treatment session. Lumen has been widened (darker tissue on right represents the more proximal normal colonic mucosa). Ridge of remaining tumor tissue (left) was then destroyed.

was completed in four sessions (Figure 1). While pulmonary metastases had increased and hepatic metastases were now present, he remained unobstructed and had no malignancy. Death from inanition occurred 77 weeks after initial laser treatment.

### Case Number Three

Patient RA is an 81-year-old man with a 6-cm cancer of the distal and mid rectum. Initial laser treatment was completed in three sessions. On follow-up, at 34 and 67 weeks, endoscopic examination revealed no gross or microscopic evidence of residual cancer. To date, no evidence of extrarectal metastasis is evident.

### Complications

Complication rates have been lower than those reported for esophageal and esophagogastric cancer thus far, with a perforation rate of approximately 3%. Incontinence has been reported very infrequently, but rectal strictures have occurred. Inability to achieve the desired goal of maintaining sufficient luminal patency has occurred in approximately 10% of patients. In our series of 30 patients thus far, post-operative bleeding has occurred in two patients, with one requiring a two-unit transfusion. One perforation has occurred. Low-grade temperature elevation and rectal discomfort, responsive to steroid suppositories and acetaminophen with codeine, have occurred transiently in several patients.

For years, now, several surgeons have reported

quite satisfactory results from nonoperative treatment in rectal cancer, utilizing electrocautery techniques. One might ask whether laser treatment is simply an expensive alternative to electrocautery. It would appear, however, that laser treatment offers several advantages over electrocauterization. The procedures are done under standard endoscopic techniques, utilizing intravenous sedation. Anesthesia has not been necessary. Tissue edema and discomfort seem to be considerably less with laser treatment than with electrocautery. In addition, if the patient's clinical condition permits, all procedures are done on an outpatient basis.

In summary, then, endoscopic laser treatment in colorectal neoplasia appears to be technically feasible in the vast majority of patients; initial treatment can be completed in less than a week's time and may be performed as an outpatient procedure. The use of laser does not preclude concomitant treatment (eg, infusion chemotherapy for extracolonic metastases, pelvic irradiation) and may be repeated for recurrent disease. At the present time, those patients most suitable for laser treatment would include those with well-advanced disease, the elderly, the poor surgical risks, and those who refuse colostomy. The use of laser for curative intent, even in rectal cancers, remains an intriguing future possibility; at the present time, limitations in accurate staging techniques

Table 2. Colorectal Cancer (Through 1/26/86)

Patient	Age	Metastases at Presentation	Transfusions	Survival (weeks)
MH	85	Liver	0	98 CHF
DB	85	Lung	2	77 inanition
RA	81	—	2	67+
PC	68	Liver	0	24 inanition
GB	78	Liver	2	24 inanition
MR	65	Pelvis	0	9 sepsis, pneumonia
NP	81	Liver	0	9 congestive failure
JG	80	—	0	37+
LB	70	Liver, bone, lung	2	7 inanition
OD	79	—	0	23+
ES	77	—	0	17+
BK	72	Liver	0	13+
DG	57	Pelvis, abdomen	0	9+
BW	65	Abdomen, pelvis	0	7+
IH	75	—	0	1+

make nonoperative endoscopic "curative" treatment a questionable approach in a good operative candidate.

### Laser Therapy — Present and Future

While laser use and experience have increased exponentially over the past few years, laser treatment of gastrointestinal disorders is still in its infancy. Although early experience is encouraging, it is important to note that, other than in a few prospective, randomized controlled trials of laser in the treatment of bleeding peptic ulcer disease, the accumulated data thus far have been nonrandomized and observational. Thus, lasers will have to be "proved" to be effective — at least as effective as the competing alternative modalities. From what is known thus far, however, it would certainly seem there will be a place for lasers in gastroenterology, either as a sole modality or in an adjunctive role, depending on the clinical situation.

With regard to photocoagulation in gastrointestinal hemorrhage, lasers are expensive and relatively immobile — that is, the patient must come to the laser and not vice versa. There are now several nonlaser therapeutic modalities available for use in the control of acute gastrointestinal hemorrhage. How these other devices rank with the laser is not yet known, but at one-twentieth the cost, nonlaser thermal devices would appear to be a better buy for community hospitals.

With regard to the use of the laser in gastrointestinal neoplasia, there are numerous important ques-

tions still unanswered. Little is known about the importance of the timing of laser treatment with adjunctive therapy, eg, should laser treatment be used prior to, concurrent with, or subsequent to radiotherapy or chemotherapy? Does laser therapy cause release of tumor antigens into the circulatory system? (Would this enhance the body's immune response to the

## *Other uses of the laser in gastrointestinal disorders are now emerging.*

cancer or hinder it?) Would preoperative treatment of resectable gastrointestinal cancers be helpful in decreasing the spread of micrometastases, by virtue of its decreasing the vascularity of the tumors?

Nonhuman experimental studies and large cooperative studies will be important. Other uses of the laser in gastrointestinal disorders are now emerging, including use in the treatment of surgical anastomotic strictures (especially colocolonic),<sup>5</sup> peptic strictures, biliary tract tumors, and internal drainage of pancreatic pseudocysts (eg, laser-induced cystogastrostomies). Reports of experience in these areas consist merely of case reports at the present time.

Finally, laser technology itself is still in its infancy. If analogies from laser use in nonmedical areas

are applicable, we can expect to see incredible changes in technology and increasing use of existing technological devices. New laser fibers are being investigated which will allow coaptation of vessel walls in larger blood vessels, thus allowing more effective photocoagulation. Other contact lasers will allow a much more powerful effect in the target tissue. In addition, lasers currently utilize only a small fraction of available wavelengths in the optical spectrum. Other wavelengths might prove to have more appealing properties for use in medicine. The development of tuneable lasers would allow the concurrent use of a variety of the laser types, all from the same machine. Technical problems with the laser fibers themselves will necessitate improvement. Finally, nonthermal laser devices are just beginning to be studied. These "pulsed" lasers will interact with specific molecular structures, markedly increasing the

specificity of effect in the target organ. "Star Wars" has indeed come to medical science. One hopes the results will be beneficial. □

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*Mark H. Mellow, MD, is a clinical associate professor of medicine at the University of Oklahoma College of Medicine. He has been a lecturer and instructor at numerous endoscopic laser surgery courses for physicians throughout the US. A 1968 graduate of the New York Medical College, Dr Mellow holds memberships in many professional organizations.*

## Coming in September . . .

Manuscripts being considered for publication in September include an article on cat-scratch disease, a study of *Legionella pneumophila* in Oklahoma, and an evaluation of a bacteria filter for volume ventilators.

# Fishing for a Worm

LAWRENCE E. C. JOERS, MD

**Screwworm infestation, caused by any of a variety of blowflies, can and does cause severe commercial loss among livestock. However, it is seldom encountered in humans. In the case described here, an elderly man was stung on the left eyebrow by some type of insect. About three weeks later, a developed screwworm larva was found trying to exit through the patient's left lower eyelid.**

It was early morning and I was making rounds at the hospital. The clinic was not yet open, and those who thought they needed care before office hours came to the emergency room at the hospital.

This morning, an elderly man was waiting, apologetically, for me. When I was able to see him, he complained that his left eye had bothered him for several days. He said there had been no severe pain; the main problem were tears that ran down his cheek, keeping it wet most of the time.

I carefully examined the eye but found no evidence of foreign body or injury to the eyeball, and there was no inflammation. I did notice a tiny perforation in the skin on the outside of the lower lid, near its middle. There was some moisture on the lid, but the patient could remember no injury. I suggested that he might have injured it without knowing it. I said that it would probably heal quickly without more trouble, and I invited him to return in a day or so if it had not entirely cleared up. He agreed.

At noon I stopped again at the hospital. To my surprise the old fellow was waiting for me in the ER.

He insisted that things were getting much worse and that he had to have something done at once. Pain was increasing, and the water ran down his cheek all the time.

I really was puzzled to know what to do for him, so I began again to examine the eye. Suddenly, I noticed the tiny opening on the lower lid was becoming larger, and water was oozing out of it. This was confusing, but while I watched, a tiny head appeared, then was gone again before I could act.

I questioned the patient again about a possible injury. He finally remembered that about three weeks previously, a fly of some kind had stung him on his left eyebrow. He had swatted it and had noticed nothing more until three days ago.

With a tiny thumb forceps, I tried for some time to catch the tiny head as it made each appearance, but I was unable to do so before it disappeared.

I explained to the patient that I would have to "cut" in order to help him. He agreed. The face was prepared and draped for surgery, and local anesthesia was injected. A transverse incision was made through the tiny opening, and the moderately scarred channel was found (Fig 1). It was followed carefully over the malar bone and into the orbit of the eye. The length of the tube amazed me; it also worried me as it continued beneath the eyeball. Finally it ended in a very moist chamber, and crawling back into the end of it was an unhappy screw worm (Fig 2). The worm was promptly fished out with an instrument and dropped into a small bottle containing alcohol.

A few stitches were used to close the incision. With a sterile eyepad taped in place, a satisfied pa-

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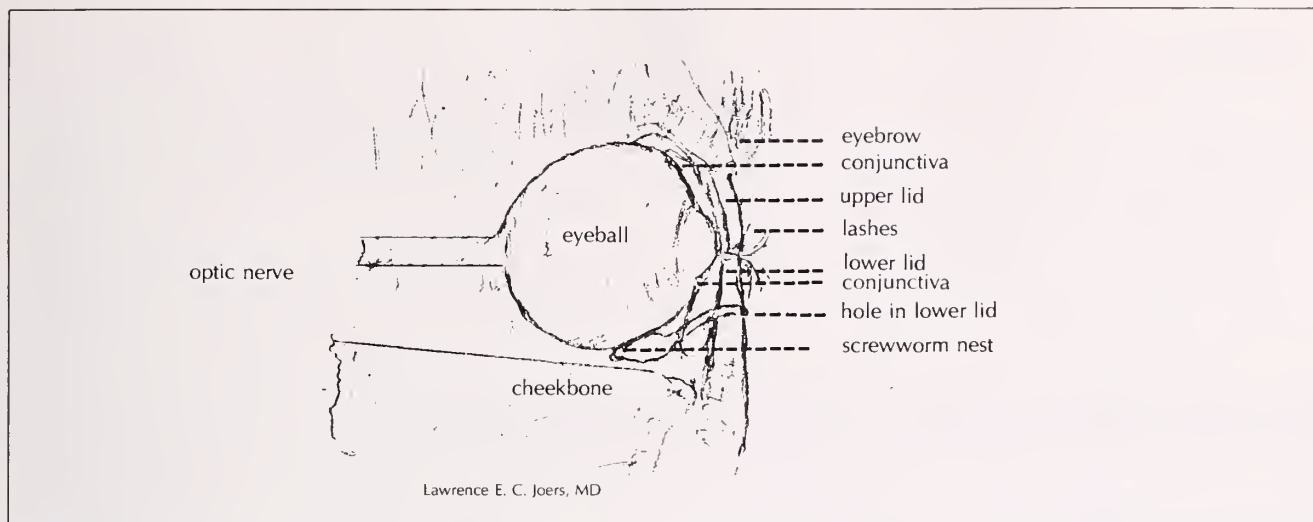


Fig 1.

tient started for home. The wound healed by first intention, and the happy old man gets a kick out of reminding me, at every opportunity, that I "cut a worm out of his eye."

It is apparent that a blowfly deposited an egg in the patient's left eyebrow when he thought he was being stung three weeks before. The worm that resulted, while developing, must have migrated around the lateral angle of the left eye, and then arranged comfortable lodging in the soft tissues beneath the eyeball. The sinus leading to the skin of the lower lid indicated that the larva, or worm, was preparing to emerge soon. At that time it would drop to the ground where it would pupate before becoming a fly.<sup>1</sup>


In regions where cattle, horses, or sheep are raised commercially, screwworms have been known to cause serious problems. Although this was the first and only case of human infestation that I have encountered, there are records of other human infestation by screwworm.<sup>2</sup>

The Encyclopaedia Britannica reports that there are several species of blowflies in North and South America which produce the screwworm larvae. The larva receives its name because of its shape. Its body is encircled by tiny ridges, which are covered with tiny bristles, giving it a screwlike appearance.

Most blowflies deposit their eggs in open wounds, and the larvae usually live on decaying and dead

tissue. During World War II, some species were grown under sterile conditions, and the larvae, or maggots, were put into wounds to clean up pus and dead tissue. Because screwworm larvae are equipped with cutting jaws and live on living tissue, they could not be used in that type of treatment. Each female blowfly supposedly deposits 250 to 300 eggs in or near the wound. The larvae then burrow into the tissue and live there until ready to drop to the ground to mature.

Myiasis, or severe infestation, may lead to death of the host animal. This has been especially true with sheep. Numerous methods of control have been tried, and best results seem to have been achieved by sterilization of the male fly.<sup>3</sup>

This experience occurred in Jay, Oklahoma, a few years ago. At that time it was thought that the state had pretty well eliminated the curse of the screwworm from her livestock. There must have been one pregnant fly left, and she was able to deposit a fertile egg in the eyebrow of my patient. 

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2. The same.
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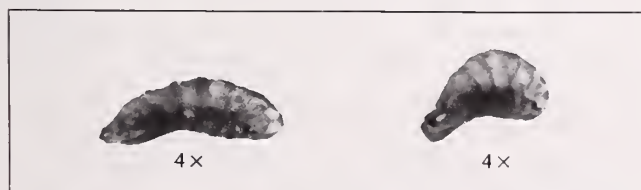


Fig 2.

# Prostaglandins and Psychiatry

JAMES R. ALLEN, MD

Since their discovery half a century ago, the prostaglandins have been found to play an important role in a growing number of conditions. Although much evidence is as yet speculative, the elucidation of their roles in health and disease greatly enriches — and complicates — our understanding of mind-body interactions and may well break down our current ideas on the separation of medicine and psychiatry.

Over half a century ago, Lieb and Kurzrock<sup>1</sup> observed that when artificial insemination was used in the treatment of sterility, the semen injected into the uterine cavity was often rapidly extruded. Investigating the actions of semen on uterine muscle, they found that sometimes the muscle relaxed and sometimes it contracted, actions we would explain today through the concept of tachyphylaxis and the nature of dose-response curves.

In the 1930s, Von Euler observed that the intravenous injection of human semen and extracts of the vesicular glands of sheep lowered arterial blood pressure and stimulated isolated uterine and intestinal smooth muscles. He demonstrated that the active principal was a soluble lipid acid different from all other known substances with similar biological activities. For many years these substances had been thought to exist only in semen, and Von Euler named

them prostaglandins. This name has persisted, although subsequent research has demonstrated that these substances are probably made by all tissues, with the possible exception of mature red blood cells.

## Chemistry

**Prostaglandins.** Prostaglandins (PGs) are products of fatty acids released from membrane phospholipids. A fatty acid, cyclooxygenase, catalyses fatty acids (primarily arachidonic acid) to the PG endoperoxides PGG<sub>2</sub> and PGH<sub>2</sub>. These endoperoxidases are then converted into compounds such as PGI<sub>2</sub> (prostacyclin), PGE<sub>2</sub>, TXB<sub>2</sub> (thromboxane B<sub>2</sub>), and PGD<sub>2</sub> (prostaglandin D<sub>2</sub>), which seems particularly important in the central nervous system.

Dietary linoleic acid, an essential fatty acid, is converted into dihomogamalinoleic acid (DGLA), then into the endoperoxides from which PGE<sub>1</sub>, thromboxane B<sub>2</sub>, and the prostaglandin F<sub>1</sub>-alpha are formed.

PGs are categorized on the basis of the number of double bonds they contain. Thus, a PG with two double bonds is called PG<sub>2</sub>. Arachidonic acid is 5, 8, 11, 14 eicosatetraenoic acid and forms products with two double bonds. These compounds seem to be the ones preferentially synthesized in humans, although two other substrates (3, 11, 14 eicosatrienoic acid [dihomo-γ-linoleic acid] and 5, 8, 11, 14, 17-eicosapentaenoic acid) can be converted to related metabolites. Metabolites of the former have one double bond and

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are labeled with the subscript 1; products of the latter have three double bonds and are labeled with the subscript 3.

**Leukotrienes.** While studying arachidonic acid, Samuelson and his colleagues<sup>2,3</sup> isolated substances with three conjugated double bonds from white cells. These they call leukotrienes (LTs). Actually, these substances are formed by the transformation of arachidonic acid into an unstable epoxide intermediate, leukotriene A<sub>4</sub> (LTA<sub>4</sub>).

The discovery that anti-inflammatory drugs such as indomethacin and aspirin inhibit cyclooxygenase, an important enzyme in the prostaglandin pathway, stimulated research which has now demonstrated that the prostaglandins and leukotrienes are of importance in the pathogenesis of many medical, reproductive, and surgical disorders. Their involvement in causing patent ductus arteriosus and other congenital heart defects suggests they have a role in organogenesis.

In 1965, Horton described the sedative properties of the prostaglandins E<sub>1</sub>, E<sub>2</sub>, and E<sub>3</sub> on chicks. Studies on the action of lithium on adenylyl cyclase—cyclic adenosine monophosphate (AMP) have shown that lithium reduces PGE<sub>1</sub>-induced stimulation of adenylyl cyclase, and that manic patients show excessive synthesis of and depressed patients a reduction of PGE<sub>1</sub> in platelets. Lithium selectively inhibits PGE<sub>1</sub> synthesis, and tricyclic antidepressants antagonize the actions of prostaglandins, especially those of PGE<sub>2</sub>.

Apparently arachidonic acid is a precursor of several physiologically active substances whose precise roles in health and disease deserve close scrutiny. Obviously, some of our current hypotheses will be disproved, and others will emerge to replace them. However, these advances could weaken, perhaps even annihilate, our traditional division between “psychiatric” and “medical.” It is the purpose of this paper to summarize some of the current research — albeit some of it highly speculative indeed — on the suspected role of these substances in conditions traditionally regarded as either psychiatric or “psychosomatic,” although most physicians, at least theoretically, now regard almost all conditions as having biopsychosocial aspects.

## Pathophysiology in the Central Nervous System

We do not yet have specific antagonists which block specific actions of individual arachidonic acid

metabolites. The fact that effects are produced by drugs known to inhibit the synthesis of PGs does not mean that the observed effects are due only to such inhibition. Indomethacin, for example, does inhibit the formation of cyclic endoperoxides by cyclooxygenase, but also disrupts calcium flux across membranes and inhibits cyclic-AMP-dependent protein kinase and phosphodiesterase. Such drugs as do inhibit the formation of arachidonic acid and its metabolites do so early in the synthetic pathways. Therefore, they inhibit the formation of many products rather than any specific one.

There is, however, a growing amount of evidence that PGs and cyclic AMP (which seems activated, at least in platelets, by PGs) are involved in the actions of endorphins and morphine. PGs seem to modulate biogenic amines in the central nervous system as well as in peripheral organs modulating dopaminergic, noradrenergic, and serotonergic transmission. PGs modulate the release of hypothalamic peptide hormones. Both PGs and LTs have important functions as secretagogues in the production of insulin.

## The Roles of PGs and LTs in Medical and Psychiatric Disorders

**Affective disorders.** Platelet formation of PGE<sub>1</sub> is elevated in patients with mania and lowered in patients with depression, when the platelets are stimulated with half-maximal levels of adenosine diphosphate (ADP).<sup>1</sup> This finding is complemented by the finding that lithium selectively inhibits PGE<sub>1</sub> formation.

Monoamine oxidase (MAO) inhibitors inhibit PGE<sub>2</sub> synthesis, and tricyclic antidepressants antagonize PG actions. Linnoila et al<sup>18</sup> found that patients with unipolar depression have significantly elevated levels of PGE<sub>2</sub> in the spinal fluid as compared to patients with schizophrenia. Possibly this evidence of enhanced PGE production is secondary to reduced production of PGE<sub>1</sub>, which inhibits mobilization of arachidonic acid, the precursor of PGE<sub>2</sub> and TXA<sub>2</sub>.

While catecholamines, amino acids, indoles, and peptides have been implicated in the affective disorders, PGE does, as Horrohin et al<sup>4</sup> suggest, help to explain several well-established observations. Since PGE effects on calcium-dependent processes and cyclic AMP are likely to modify responses to and release of neurotransmitters, it would seem wise to include them in our hypotheses on the biochemistry of affective disorders<sup>5</sup>, as well as in hypotheses concerning drug abuse.<sup>6,7</sup>

**Psychoses.** Data concerning the role of PGs in schizophrenic psychoses are tentative and to some extent contradictory.<sup>8,9</sup> Rotrosen et al<sup>10</sup> have reported that PGE<sub>1</sub>-stimulated 3H cyclic adenosine monophosphate (3H-c AMP) is reduced in schizophrenic patients. High doses of PG antagonists cause psychotic symptoms. Penicillin, which enhances PG synthesis, has been beneficial to a group of patients with chronic schizophrenia. However, PGE<sub>2</sub> concentrations in the cerebrospinal fluid of schizophrenic patients have been reported to be higher than for normal groups by Mathe et al.<sup>9</sup> It is unclear whether this is due to a hypothesized reduction in PGE synthesis or, as Mathe et al suggest, with increased availability of PGE in schizophrenia, to some alteration in the metabolic pathways of arachidonic acid. Raised PGE could, in conjunction with other factors, influence dopamine receptor sensitivity or the number of dopamine-binding sites, thereby linking changes in prostaglandins with the dopaminergic hyperactivity hypothesis of schizophrenia.

### Effects of Psychotropic Drugs

Lithium inhibits PGE-induced cyclic AMP in human platelets, selectively inhibiting PGE<sub>1</sub> synthesis while not inhibiting PGE formation. More recent work has suggested it actually enhances 2-series PG production. This could explain several of its side effects, such as tremor, diabetes insipidus, and hypothyroidism.<sup>11</sup>

Mood-regulating drugs are effective in treating a wide range of disorders in which a disturbance in the level of PGs is either known or strongly suspected.<sup>12</sup> Lithium, for example, has been reported effective in treating chronic cluster headaches, thyrotoxicosis, leukopenia, and asthma. Tricyclic antidepressants can be useful in treating asthma, pain, migraine headache, peptic ulcer, and colitis. The demonstration of the role of PGs in these disorders suggests that the effect of these drugs may well be through the inhibition of PG synthesis.

**Anxiety disorders.** Many medications known to be effective in these conditions — benzodiazepines, beta-adrenergic blockers, phenothiazines, MAO inhibitors, and even aspirin, as well as ibuprofen and naproxen (which has been reported as effective in treating some patients with phobia and obsessive-compulsive behaviors) all have inhibitory effects on PG synthesis.<sup>1</sup>

**Physical disorders associated with psychological factors.** Probably nowhere has the role of PGs and LTs been more dramatically demonstrated than in those disorders which were once called “psychosomatic” or “psychophysiological.”

Stress has frequently been indicted as important in these conditions.<sup>13,14</sup> PGs could be involved in mediating this reaction to stressors either through enhanced tissue sensitivity or through increased production. Lymphocytes from patients undergoing cardiac surgery or childbirth have been shown to have enhanced sensitivity to PGE<sub>2</sub>.

#### ● Asthma

There is evidence implicating 2-series PGs in asthma.<sup>15</sup> Allergen challenges of lung tissue for asthmatics elicit bronchial constriction that correlates with LTs. Administration of allergens to patients produces an increase in plasma levels of PGF following induction of allergic symptoms.<sup>16</sup>

PGs have marked effects on airway smooth muscle, and asthmatics often respond to steroids which block PG synthesis.<sup>17</sup>

One subset of asthmatic patients has symptoms that are precipitated by drugs such as mefenamic acid, indomethacin, and aspirin. Such “aspirin-sensitive asthma” may involve a selective inhibition of arachidonic acid metabolism, wherein the substrate is shifted to the leukotriene pathway, producing large amounts of bronchoconstrictors.

#### ● Peptic Ulcer Disease

Gastric acid output is complex. PGE<sub>2</sub>, however, and certain of its methyl analogs inhibit gastric acid secretion and prevent the formation of duodenal and gastric ulcers.

#### ● Migraine

Lithium, tricyclic antidepressants, MAO inhibitors, beta-adrenergic blockers, steroids, and ergotamine are all effective in the treatment or prophylaxis of migraine in some patients. All inhibit PG synthesis.

These observations are complemented by the fact that the injection of PGE<sub>1</sub> or PGE<sub>2</sub> in humans often produces a throbbing headache.

#### ● Rheumatoid Arthritis

Since PGs act as mediators in inflammation and since drugs which inhibit PG synthesis alleviate the symptoms of rheumatoid arthritis, it is not surprising that human rheumatoid synovial tissues *in vitro*

produce large amounts of PGE<sub>2</sub>.<sup>18</sup> They probably participate in the pathogenesis of rheumatoid inflammation and promote osteoclastic resorption of juxta-articular bone.

### ● Thyroid Disease

The thyroid gland contains high levels of PG-like substances. PGE<sub>1</sub> mimics the action of thyroid-stimulating hormone in the thyroid by increasing the formation of cyclic AMP. Lithium, which inhibits PGE<sub>1</sub> synthesis, can induce hypothyroidism.

### ● Hypertension

LTs and PGs seem involved in the regulation of blood pressure, probably through both peripheral and arterial mechanisms.<sup>19</sup> Urinary PGE levels in patients with essential hypertension are lower than in subjects with renovascular hypertension or primary aldosteronism. It has been suggested that, in some people, essential hypertension may be due to a deficiency in the renal production of PGE.<sup>20</sup>

### ● Dysmenorrhea

Dysmenorrhea is associated with increased uterine contractions. Because of the complex nature of different factors, such as blood flow, which may be altered during menstruation, and the multifold nature of pain, a cause-and-effect relationship has not been established between dysmenorrhea and the uterine production of prostaglandins. However, dysmenorrheic women have more prostaglandins in their menstrual blood than women who have had painless periods.<sup>21,22</sup> PG-synthesis inhibitors can remit dysmenorrhea as well as premenstrual symptoms such as vomiting and diarrhea.

## Conclusion

While much of our current knowledge of PGs and LTs is still suggestive, there is increasing evidence of their involvement in psychiatric and functional illnesses as well as in the pathogenesis of a large number of "medical" illnesses. We need to include consideration of their functions in our ideas of the workings of biogenic amines, stress, and mind-body interaction. PGE<sub>1</sub> effects on calcium-dependent processes and on cyclic AMP seem to modify the release of or response to neurotransmitters. These findings and their related hypotheses, speculative as they may be, suggest radically new approaches to the investigation and treatment of several disorders and would seem to herald a dramatic revision of our traditional separation of "medical" and "psychiatric." □

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# The Mysterious Case of Sherlock Holmes's Creator

JOE D. HAINES, JR., MD

Undoubtedly, the ultimate tribute to authors is for one of their characters to achieve such popularity that the character overshadows the creator. Such events rarely occur in the world of fiction, but such was the case with Sir Arthur Conan Doyle's creation of the world's most famous detective, Sherlock Holmes.

It seems impossible that a character who starred in sixty works of fiction written almost one hundred years ago could be the object of such intense fascination by legions of devoted admirers. Nevertheless, there are scores of clubs around the world that continue to gather for lively discussions of the exploits of Sherlock Holmes, who has been called the "most famous character in fiction."

Sir Arthur Conan Doyle experienced such success with Sherlock Holmes that he may well have felt overpowered by this character, who seemed to have taken on a life of his own. To say that the stories have been and continue to be immensely popular would be a gross understatement. One writer has even advanced the notion that, with the exception of the Bible, no other writings have been published in as many different languages and editions as the tales of Sherlock Holmes.

Until recently, there was little interest in the life of the remarkable creator of Sherlock Holmes. Some

devotees have even come to believe that Sherlock Holmes and his trusted assistant, Dr Watson, were real people and that Sir Arthur merely served as Watson's literary agent. A veritable library of books and articles, countless movies, many plays, and even a musical and a ballet have been written about the "life" of Sherlock Holmes. Yet few people are acquainted with the creator of the master detective.

***Doyle's medical experience  
gave him  
a unique background  
as an author.***

Significantly, much of the latest research has been done by physicians, for Sir Arthur Conan Doyle was himself a physician as well as an author. The record reveals that Doyle was a remarkably talented man who had an amazing diversity of interests and pursuits.

Doyle was born in Edinburgh, Scotland, on May 27, 1859, and received his preliminary education at the Jesuit College of Stoneyhurst, Lancashire, England. In 1876 he enrolled at the University of Edin-



Illustration: Sidney Paget 1890

Courtesy Metropolitan Toronto Library Board

burgh's medical school and was graduated with a medical degree in 1881.

Prior to graduation, young Doyle spent seven months on an arctic whaler as ship's surgeon. Shortly after graduation he took a similar post for three months on an African steamer.

It was during medical school that Doyle came in contact with two professors on the faculty at the University of Edinburgh who had a profound influence on him. In fact, the great Sherlock Holmes was patterned after one of these professors, Dr Joseph Bell. Doyle was greatly impressed by Bell's ability to observe and then make amazingly accurate deductions about his patients. One particular interview by Dr Bell went as follows:

"I see you've served in the Army."

"Aye, sir."

"Not long discharged."

"No, sir."

"A highland regiment?"

"Aye, sir."

"A noncommissioned officer?"

"Aye, sir."

"Stationed in Barbados?"

"Aye, sir."

"You see," said the professor to his clerks, "The man was a respectful man but did not remove his hat. They do not in the army and he would have learned civil ways if he had been long discharged. He has an air of authority and is obviously Scottish. As to Barbados, his complaint is elephantiasis, which is West Indian and not British."

Compare this exchange with one of Sherlock Holmes's interviews with a client who appears in *The Blended Soldier*.

"From South Africa, sir, I perceive."

"Yes, sir," he answered, with some surprise.

"Imperial Yeomanry, I fancy."

"Exactly."

"Middlesex Corps, no doubt."

"That is so, Mr. Holmes, you are a wizard."

Holmes explains, "When a gentleman of virile appearance enters my room with such a tan upon his face as an English sun could never give, and with his handkerchief in his sleeve instead of his

pocket, it is not difficult to place him. You wear a short beard, which shows you were not a regular. You have the cut of a riding-man. As to Middlesex, your card has already shown me that you are a stockbroker from Throgmorton Street. What other regiment would you join?"

The other instructor who influenced young Doyle was Dr Rutherford, also a professor at the University of Edinburgh. Rutherford was a man of impressive bearing, who had a booming voice and a full black beard. He later served as the model for Doyle's Professor Challenger in *The Lost World*, a science fiction novel.

During medical school Doyle made his first serious attempts at writing and he sold his first story, an adventure tale. He worked as an assistant to several established medical practitioners after graduation and finally began his own practice at Southsea in 1882. His practice was almost nonexistent at times, but he continued on for eight years there.

Doyle found that he had ample time to continue writing and pursue many of his varied interests. He wrote several letters on medical topics to various medical journals and researched and wrote his thesis for his MD degree in 1885. The thesis concerned the vasomotor changes occurring in tabes dorsalis, a tertiary form of syphilis.

Doyle was also quite active as a sportsman and played on his district's football and cricket teams. He was also a pillar of the Portsmouth Literary and Scientific Society. In later years Doyle was credited with introducing cross-country skiing to Switzerland, after persuading some Swiss businessmen to send to Norway for skis.

In 1886 Doyle conceived a new character for his fiction and Sherlock Holmes was born. As Doyle relates in his autobiography:

I felt now that I was capable of something fresher and crisper and more workmanlike. Could I bring an addition of my own? I thought of my old teacher, Joe Bell. . . . If he were a detective, he would surely reduce this fascinating, but unorganized business into nearer an exact science. The idea amused me. What shall I call the fellow? First it was Sherringford Holmes; then Sherlock Holmes. He could not tell his own exploits, so he must have a commonplace as a foil . . . an educated man . . . who could both join in the exploits and narrate them. A drab quiet name for an unostentatious man. Watson would do. And so I had my puppets and wrote my "A Study in Scarlet."

Doyle's work was initially rejected by several publishers, but he eventually sold the story and the



Sir Arthur Conan Doyle

Courtesy Metropolitan Toronto Library Board

copyright for twenty-five pounds. The story resembled the style of Edgar Allen Poe, a favorite of Doyle's, and it is thought that Holmes's name was taken from Oliver Wendell Holmes, the famous physician and author of Doyle's time.

Doyle then devoted himself to several historical novels which never came close to achieving the popularity of his Sherlock Holmes tales. In 1890 he journeyed to Berlin to investigate Dr Robert Koch's proposed cure for tuberculosis. While on this trip, Doyle chanced to talk with Sir Malcolm Morris, who suggested that Doyle pursue medical specialty training. Doyle decided on ophthalmology, and in 1891 he travelled to Vienna and studied the eye for four months. He returned to London and opened an office, but saw no patients and finally decided to abandon medicine and pursue his literary career full-time.

Soon after, Doyle and another young writer, Oscar Wilde, met at a dinner in London and each agreed to write a novel for *Lippincott's Magazine*. Doyle wrote "The Sign of Four," and Wilde contributed "The Picture of Dorian Gray."

Doyle's medical experience gave him a unique background as an author. Throughout his stories many references can be found to illnesses, poisons, various drugs and their effects, and pathological findings in cadavers. In addition, some of the villains in

the Holmes stories are physicians. As Holmes said about a physician who goes wrong, he is the "first of criminals — having both nerve and knowledge."

Doyle was a great patriot and volunteered his services as a medical officer in 1899 during the Boer War. He was made superintendent of a military hospital that was full of dysentery patients. After the war, Doyle wrote numerous articles concerning his experiences and the circumstances in South Africa, and he was awarded a knighthood in 1902 for his services.

Inevitably, Doyle became involved in some real-life detective work in several instances, and throughout his life was the champion of the underdog, always rooting for the amateur. This philosophy carried over into his writings, as Holmes was always portrayed as the amateur detective constantly outwitting the professional police detectives.

In the case of George Edalji, Doyle believed that the man had been falsely accused and imprisoned, and he wrote a series of articles setting forth his reasoning. The result was the appointment of a special commission that investigated Doyle's theory, and Edalji was subsequently cleared of the charges and set free.

Two years later, Doyle became involved in the case of Oscar Slater. Slater had been convicted and sentenced to prison for the murder of an elderly woman in Glasgow. Once again, Doyle's investigation turned up evidence that resulted in the freeing of the falsely accused man.

As the Sherlock Holmes tales gained in popularity, the character began to overshadow his own creator. Doyle believed that his historical novels were his most noteworthy literary contributions and further felt that the Holmes tales were restricting him. Finally, Doyle wrote to his mother: "All is very well down here. I am in the middle of the last Holmes story, after which the gentleman vanishes, never to return. I am weary of his name."


And thus, the world's most famous detective and, some say, most famous fictional character of all time, was laid to rest. During the remainder of Doyle's life he remained intensely active in a variety of areas. He wrote numerous science fiction novels, in which the unforgettable Professor Challenger, modeled after Dr Rutherford, played a prominent role.

Shortly after WW I broke out, Doyle organized a volunteer military company and was an active participant in the drills. He made numerous suggestions for personal armor for foot soldiers and collapsible rafts and life preservers for the sailors. Some of his

suggestions were adopted and, in addition, he was asked to write an official history of WW I. Doyle produced a six-volume work entitled *A History of the Great War*.

During the last ten years of his life, Doyle embarked with characteristic vigor on an investigation of spiritualism. He accumulated a 2,000-volume library on the subject, and he studied haunted houses, levitation of bodies, methods of communicating with the dead, and similar supernatural phenomena. Doyle wrote extensively on spiritualism and travelled all over the world promoting this cause.

Finally, Doyle's advancing age and weakening health proved too great a burden; he suffered a heart attack and died shortly thereafter, on July 7, 1930. He had looked forward to death and concluded, "I have had many adventures. The greatest and most glorious of all awaits me now."

And so, the great man, who will probably never come close to the fame achieved by one of his own characters, was laid to rest. His epitaph reads, "Arthur Conan Doyle, Knight, Born May 27, 1859, Steel True, Blade Straight." For millions of readers, however, Doyle continues to live on in the character of the world's most remarkable detective, Sherlock Holmes. 

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*Joe D. Haines, Jr., MD, is a 1981 graduate of the University of Oklahoma Tulsa Medical College. He practiced emergency medicine in Skiatook for several years before resuming his medical training this summer at OUTMC, where he is now specializing in family practice.*



## Cholesterol Screening

Coronary heart disease remains the major cause of death and disability in the United States, despite recent declines in coronary heart disease mortality. Epidemiologic evidence has clearly established high blood cholesterol and high blood pressure as two of the major modifiable risk factors associated with coronary heart disease.

Clinical evidence indicates that lowering definitely elevated blood cholesterol levels, specifically blood levels of low-density lipoprotein cholesterol, will reduce heart attacks due to coronary heart disease. Judging from the studies conducted by the Lipid Research Clinics Coronary Primary Prevention Trials, both men and women with blood cholesterol levels above the 75th percentile should be treated by diet or diet and medication regimes. Further, experts

Age	Moderate Risk	High Risk
20-29	Greater than 200 mg/dl	Greater than 220 mg/dl
30-39	Greater than 220 mg/dl	Greater than 240 mg/dl
40 & over	Greater than 240 mg/dl	Greater than 260 mg/dl

are recommending that the American population lower its dietary intake of calories, saturated fats, and cholesterol.

The National Institutes of Heart, Lungs and Blood have established a goal to reduce blood cholesterol in the American population to 180 mg/dl for adults under age 30 and 200 mg/dl for those age 30 and older. The detection levels have been further defined for age and risk, moderate and high. The accompanying table reflects these values.



DISEASE	May 1986	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	0	4	8	6
CAMPYLOBACTER INFECTIONS	30	82	95	—
ENCEPHALITIS, INFECTIOUS	3	8	13	14
GIARDIA INFECTIONS	14	67	82	—
GONORRHEA (Use ODH Form 228)	1084	5236	4989	5926
HAEMOPHILUS INFLUENZAE INVASIVE DISEASE	21	102	95	—
HEPATITIS A	24	133	240	210
HEPATITIS B	16	70	85	100
HEPATITIS, NON-A NON-B	4	21	32	—
HEPATITIS UNSPECIFIED	3	24	35	71
MEASLES (RUBEOLA)	7	11	0	2
MENINGITIS, ASEPTIC	7	21	21	31
MENINGITIS, BACTERIAL (non-meningococcal, non H. Influenzae)	4	35	35	31
MENINGOCOCCAL INFECTIONS	2	13	18	19
PERTUSSIS	3	24	67	62
RABIES (Animal)	9	29	51	76
ROCKY MOUNTAIN SPOTTED FEVER	16	22	33	38
RUBELLA	0	0	1	1
SALMONELLA INFECTIONS	30	147	116	129
SHIGELLA INFECTIONS	15	63	67	99
SYPHILIS (Use ODH Form 228)	11	73	86	88
TETANUS	0	0	0	0
TUBERCULOSIS	32	99	111	129
TULAREMIA	0	2	4	6
TYPHOID FEVER	0	1	0	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	10
BRUCELLOSIS	0
LEGIONNAIRES DISEASE	5
MALARIA	2
REYE SYNDROME	3
TOXIC SHOCK SYNDROME	15
<b>RABIES</b>	
MAYES	Skunk 1
LINCOLN	Skunk 1
WASHITA	Skunk 1

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**Norman L. Dunitz, MD**, new president of the OSMA, stands with the other newly elected presidents of state medical associations for a formal presentation to the assembly.



**Perry A. Lambird, MD**, Oklahoma City, and **Ed L. Calhoon, MD**, Beaver, go over their delegate handbooks.



**Rick Ernest**, executive director of the Oklahoma County Medical Society, and **David Bickham**, executive director of the OSMA, confer before their next meeting.

**C. S. Lewis, Jr., MD**, Tulsa, president of the American College of Physicians, and **William O. Coleman, MD**, Oklahoma City, enjoy one of the presentations in the House of Delegates.





## AMA '86



**John E. Merriman, MD, Tulsa,** watches the proceedings with obvious interest.

**Tulsa was ably represented** by William C. Stone, MD, president of the Tulsa County Medical Society, and Paul L. Patton, TCMS executive director.

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### *Should you be on resource register?*

## DHS establishing registers for referrals of multihandicapped

The Oklahoma Department of Human Services, in attempting to establish and improve available services to the multihandicapped, is establishing professional registers for referrals. These registers will list individuals with backgrounds or experience in evaluating and treating persons with multiple handicaps.

If you provide evaluation and/or treatment for the multihandicapped, you can complete a survey form that will place your name on the resource register for your profession. When evaluation or treatment services are needed for a multihandicapped person in your geographic area, individuals making referrals will have access to these professional registers.

Professional areas included are medicine (specialty area), psychology, physical therapy, occupational therapy, education, and speech pathology/audiology.

Survey forms may be obtained from Zane LaCroix, Supervisor, Speech and Hearing Services, Oklahoma Department of Human Services, 4901 North Lincoln, Oklahoma City, OK 73105.



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*"The single most important variable"*

## DNA content of tumor offers key to colon cancer prognosis

The DNA content of colorectal tumors offers a significant indication of prognosis, concludes a report in the *Journal of the American Medical Association*. Tumor ploidy (chromosome set) was shown to be the single most important prognostic factor of any variable examined, suggest results of the largest such study to date.

William Kokal, MD, and colleagues of the City of Hope National Medical Center in Duarte, Calif, studied 77 patients with primary colorectal carcinoma that was resected between 1974 and 1980. "Overall, patients with aneuploid (an abnormal number of chromosomes) tumors had a significantly higher recurrence rate and significantly shorter disease-free and overall survival times than did patients with diploid (normal set of chromosomes) tumors," the researchers report. Content of tumors was analyzed by flow cytometry.

"In fact, the DNA content of the tumor was the single most important variable in predicting recur-

rence and death from colorectal carcinoma, even more important than stage of the disease," they add. Other studies have established many clinical and histological parameters important in prognosis of this cancer, but in the past it was unclear whether tumor ploidy was the result of the stage of the illness or other known prognosis factors.

Commenting editorially, Leopold G. Koss, MD, and Ellen Greenebaum, MD, of the Albert Einstein College of Medicine, Bronx, New York, note, "There are a great many publications on DNA content of various cancers, but relatively few with conclusions of clinical value, either because of inadequate follow-up information or because of other deficiencies in the experimental design."

Kokal and colleagues provide supportive documentation for work that Koss and Greenebaum themselves previously accomplished in the field. "Although this evidence is encouraging, it should not be considered conclusive," they caution. □

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## Compendium of AIDS articles from JAMA available by mail

A compendium of articles on AIDS from the *Journal of the American Medical Association* now is available in book form. *AIDS: From the Beginning* contains virtually everything published about the acquired immunodeficiency syndrome in *JAMA* since the deadly new disorder was identified.

In addition, the book contains new introductory information on epidemiology from James Curran, MD, and W. Meade Morgan, PhD; on virology by Robert Gallo, MD, and Marjorie Robert-Guroff, PhD; and on treatment by Paul Volberding, MD, and Lawrence Kaplan, MD.

The volume also features a selected bibliography of the major articles on AIDS from world medical literature.

A 450-page book in magazine size, *AIDS: From the Beginning* contains all of the original contributions on AIDS as well as Leads from MMWR, *JAMA* Medical News, Letters to the Editor, and editorials. Priced at \$22.50, the information resource can be ordered from the AMA's Book and Pamphlet Fulfillment department at 535 North Dearborn Street, Chicago, IL 60610, or by phone: (800) 621-8335 (in Illinois, call collect: 312/645-4987). □

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College notes indications have changed

## ACP issues guidelines on use of diagnostic lumbar puncture

Use of the diagnostic spinal tap (lumbar puncture) and the routine tests performed on the cerebrospinal fluid should be individualized for each patient, according to a recent recommendation from the American College of Physicians (ACP), the nation's largest medical specialty society.

As with many other older medical procedures, indications for performing lumbar punctures have changed with the advent of newer noninvasive diagnostic techniques. The ACP report provides clinicians with current guidelines on the use of the lumbar puncture, which was originally described and used in the late 1800s and now is considered useful in the diagnosis of four major disease categories: meningeal infection, subarachnoid hemorrhage, central nervous system malignancy, and demyelinating diseases.

Unlike blood or urine samples, cerebrospinal fluid samples are not easily obtained. Complications range from mild discomfort to fatality. Patients must be

positioned correctly and given adequate reassurance throughout the procedure. Small diameter needles (20 gauge or less) can then be used to withdraw a sample of cerebrospinal fluid from the spinal cord. By using these small gauge needles and requiring the patient to remain in a prone position for several hours following the procedure, the physician can decrease the chances of a postprocedure headache, the most common complication, for most patients.

The statement and a supporting article by Keith I. Marton, MD, and Alison D. Geon, MD, which appear in the June 1986 issue of *Annals of Internal Medicine*, say that testing costs could be decreased by 25% to 50% if routine tests performed on cerebrospinal fluid samples were limited to a cell count, a cell differential, and a glucose level. Other tests, such as a gram stain and a bacterial culture, should be ordered only if the initial tests are abnormal or if the patient's clinical history indicates that further tests are re-

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## Lumbar puncture (continued)

quired. According to the recommendation, the protein level, which is often included in the battery of routine tests, is a nonspecific and relatively insensitive measure that usually does not add any useful information to the total cerebrospinal fluid analysis.

Prepared through ACP's Clinical Efficacy Assessment Project (CEAP), the recommendation advises physicians not to perform the lumbar puncture at all if the laboratory tests will yield no useful findings (for example, in patients without headache, stiff neck, fever, or clear neurologic abnormalities) or if there is a high probability of complications for the patient (such as in those patients who have a mass in the central nervous system or decreased levels of clotting factors).

According to the CEAP statement, cytologic examinations of the cerebrospinal fluid are useful for diagnosing malignant meningitis, and increasing use of rapid assays for bacterial and fungal antigens are improving the accuracy of this test when central nervous system infection is suspected. The statement continues by noting that although the lumbar puncture and a cytologic examination of the fluid is primarily used for diagnosing bacterial meningitis, a patient's clinical response — rather than serial cerebrospinal fluid findings — should be used to determine whether a patient's antibiotic therapy should be continued. A spinal tap also can be used to diagnose mycobacterial and viral infections although, according to the recommendation, its value in diagnosing a possible viral infection seems to lie in excluding more serious conditions.

Due to the possible complications of the lumbar puncture and the increasing use of computed tomography (CT), notes the college, the role of the spinal tap in diagnosing subarachnoid hemorrhage is di-

minishing. For those patients with a clear-cut history and a positive CT scan, the spinal tap often is not necessary. Despite a high correlation between the presence of IgG abnormalities in the cerebrospinal fluid and the presence of multiple sclerosis, the recommendation says that the use of the lumbar puncture adds little to the overall accuracy of the diagnosis of either multiple sclerosis or of polyneuropathies.

According to data examined thus far, the spinal tap does not appear to be very useful in diagnosing a hemorrhagic stroke or other cerebrovascular disorders. The lumbar puncture also is not useful for diagnosing dementia, although it is commonly performed as part of the dementia evaluation due to concern about syphilis and cryptococcal meningitis. According to the CEAP recommendation, patients with cryptococcal meningitis usually exhibit specific symptoms other than dementia, and syphilis rarely causes dementia. □

## AMA still wants your comments

### Findings reported by AMA in ongoing DRG monitoring project

The American Medical Association, in a recent issue of its *Hospital Medical Staff Newsletter*, published a status report on its ongoing DRG Monitoring Project.

In tallying the responses to date, the AMA said that 66% of the comments concerning quality of care stated that the quality had deteriorated or would deteriorate if the system remains unchanged. Eighty-five percent of the physicians commenting on the cost of care reported that reimbursement in their hospitals was inadequate for one or more DRGs. Regarding admission and discharge policies, 43% of the respondents reported feeling pressure to discharge patients early, limit laboratory testing, and readmit patients at a later date for treatment of secondary conditions. Of the comments on relations between physicians and hospital administrators, 42% felt relations had deteriorated under the DRG system.

The monitoring project is still underway. Physicians wishing to relate their experiences, positive or negative, with the DRG system should direct their correspondence to: AMA's DRG Monitoring Project, Department of Health Care Financing, PO Box 10947, Chicago, IL 60610. □

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## Smoking increases chance of cervical cancer, report says

After eliminating other potentially confounding variables, it appears that women who smoke 40 or more cigarettes a day or those who smoke for 40 or more years experience a twofold increase in risk for invasive squamous cell cervical cancer, a newly published report contends. Furthermore, those who smoke non-filter cigarettes are at especially high risk.

Louise A. Brinton, PhD, of the National Cancer Institute, Bethesda, and colleagues studied 480 patients with invasive cervical cancer and 797 control subjects in five varied geographical regions of the United States from April, 1982, to January, 1984. The researchers were interested in determining whether the smoking associations merely reflect confounding by other cervical cancer risk factors.

"After adjustment for appropriate confounding variables, we found that women who reported ever having regularly smoked cigarettes had a 50% elevated risk compared with nonsmokers," the researchers say in the *Journal of the American Medical*

*Association*. "This study, however, indicated the importance of accounting for additional risk factors in assessing the relationship between smoking and cervical cancer, particularly since smoking was correlated with measures of sexual activity that were major predictors of risk in this population," they add.

"It is of note that those who discontinued smoking two or more years prior to diagnosis demonstrated no significant excess risk compared with nonsmokers," they emphasize. "The declining incidence rate of cervical cancer, however, suggests that the impact of smoking is not as potent as for other smoking-related cancers, such as that of the lung, a cancer that has been rising steadily among women."

In a related study, researchers caution physicians on proper use of nicotine gum for their patients. "Physicians should probably continue to emphasize to patients the need for gradual reduction of nicotine gum," according to a study done by John R. Hughes, MD, and colleagues from the University of Minnesota

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## DEATHS

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### **Robert E. Campbell, MD** 1927 - 1985

Clinton native Robert Emerson Campbell, MD, died September 23, 1985. He was 58 years old. Dr Campbell was graduated from the University of Oklahoma College of Medicine in 1954. He completed a residency in ophthalmology at Oklahoma City's University Hospital and practiced for a year in Amarillo before returning to Oklahoma City in 1958.

### **Marianne Elsbeth Kosbab, MD** 1924 - 1986

Marianne Kosbab, MD, a psychiatrist at Tulsa's City of Faith Hospital, died June 13, 1986. Born in Goettingen, West Germany, Dr Kosbab was graduated from the University of Heidelberg in 1957. She interned in Omaha, Neb, and practiced in West Germany, Virginia, and New York before coming to Oklahoma.

### **William W. Rucks, Jr., MD** 1903 - 1986

Life Member William W. Rucks, Jr., MD, died in Oklahoma City's Presbyterian Hospital on June 27, 1986. The Guthrie native earned his medical degree in 1928 at Vanderbilt University and began his practice in 1931 as an internist at Oklahoma City Clinic. After serving in the US Army from 1942 to 1945, he returned to the clinic. He went on to become a volunteer faculty member and clinical professor emeritus at the University of Oklahoma School of Medicine, as well as chairman of the Department of Medicine and Chief of Staff at Presbyterian Hospital. He served as president of the Oklahoma Internists Society, the Oklahoma City Academy of Medicine, and the Oklahoma County Medical Society. He was also governor for Oklahoma of the American College of Physicians. Dr Rucks was featured as one of the state's Leaders in Medicine in the October 1985 OSMA JOURNAL.

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Most is preventable or curable

## Developing nations harbor more than 80% of all blindness

More than 80% of all blind persons live in the developing countries of Africa, Asia, and Latin America; furthermore, half to three-fourths of all blindness in the world is either curable or preventable, according to a report in the *Journal of the American Medical Association*.

Khalid F. Tabbara, MD, of King Saud University, Riyadh, Saudi Arabia, and Dennis Ross-Degnan, MSPH, of the International Eye Foundation,

Bethesda, studied the prevalence and causes of blindness among 14,577 of Saudi Arabia's settled population and among 2,233 bedouins.

"The survey revealed that 1.5% of the population is blind and another 7.8% is visually impaired according to the World Health Organization definition," the researchers say. "The most common causes of blindness include: cataract, trachoma, nontrachomatous corneal scars, refractive errors, congenital anomalies, failed medical or surgical treatment, and glaucoma." Blindness is not only a personal tragedy, they say; it represents a major socioeconomic burden.

In Saudi Arabia, as in most developing countries, cataracts account for most blindness (52.8%). Seven percent of the Saudi population, and 42% of those older than 40 years have a cataract or its resulting complications. Only 16.6% of these persons have had surgery. The researchers note a disturbing frequency of surgical complications in Saudi Arabia (19% for cataract surgery and 13.8% for other intraocular procedures). "In fact, 4.4% of all blindness in Saudi

## Cervical cancer (continued)

in Minneapolis. The study provided "a rigorous and generalizable test of whether nicotine gum can induce (or maintain) physical dependence on nicotine." A significant finding was that "regardless of the cause, the symptoms from stopping the use of nicotine gum were aversive and, in two cases, appeared to cause relapse." □

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## IN MEMORIAM

### 1985

<i>E.C. Lindley, MD</i>	<i>March 1</i>
<i>Charles W. Freeman, MD</i>	<i>March 5</i>
<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>Forest R. Brown, MD</i>	<i>March 19</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hanna B. Karam, MD</i>	<i>March 28</i>
<i>John R. Cotteral, MD</i>	<i>April 30</i>
<i>Ernest S. Kerekes, MD</i>	<i>June 8</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin Jesse Nelson, MD</i>	<i>June 13</i>
<i>Robert L. Kendall, MD</i>	<i>June 21</i>
<i>Marion K. Ledbetter, MD</i>	<i>July 3</i>
<i>James Floyd Moorman, MD</i>	<i>August 8</i>
<i>Oscar R. White, MD</i>	<i>August 14</i>
<i>Maurice P. Capehart, MD</i>	<i>August 29</i>
<i>Meredith M. Appleton, MD</i>	<i>September 7</i>
<i>Robert A. Northrup, MD</i>	<i>September 8</i>

<i>Carl H. Bailey, MD</i>	<i>September 9</i>
<i>Hugh B. Spencer, MD</i>	<i>September 13</i>
<i>Bernice E. McCain, MD</i>	<i>September 14</i>
<i>Minard F. Jacobs, MD</i>	<i>September 30</i>
<i>Robert Ray Rupp, MD</i>	<i>October 2</i>
<i>William C. Moore, MD</i>	<i>October 24</i>
<i>Michael Wayne Durbin, MD</i>	<i>November 13</i>
<i>Alan Luis Gorena, Jr., MD</i>	<i>November 19</i>
<i>William Hampton Garnier, MD</i>	<i>November 20</i>
<i>Jesse Ray Waltrip, MD</i>	<i>November 30</i>
<i>Charles F. Obermann, MD</i>	<i>December 30</i>

### 1986

<i>Alexander Poston, MD</i>	<i>January 3</i>
<i>Francis M. Duffy, MD</i>	<i>February 5</i>
<i>Edward L. Leonard, MD</i>	<i>February 14</i>
<i>Fred D. Switzer, MD</i>	<i>May 10</i>
<i>Phillip Wade Jones, MD</i>	<i>May 18</i>
<i>Marianne Elsbeth Kosbab, MD</i>	<i>June 13</i>
<i>William W. Rucks, Jr., MD</i>	<i>June 27</i>

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## Blindness (continued)

Arabia is iatrogenic, caused by a failed medical or surgical therapy," they report.

Trachoma (caused by *Chlamydia trachomatis*) was the second leading cause of blindness in the study population, representing 10.5% of cases. Although its prevalence is declining, possibly due to improved treatment and hygiene, at least 122,000 Saudi Arabians have severe eyelid deformities from trachoma that will eventually cause blindness without surgery. The researchers predict that establishment of surgi-

cal competence, increasing facilities for dispensing of corrective lenses, and improved capabilities for treating trauma and infection would dramatically reduce the prevalence of blindness in Saudi Arabia.

Although Saudi Arabia is rapidly becoming a developed country, its patterns of blindness reflect health problems of many developing countries, observes Alfred Sommer, MD, of the Wilmer Institute, Baltimore, in a related editorial. "The enormity of blindness can be prevented or avoided through commitment to imaginative application of existing technology." □

## How's that again?

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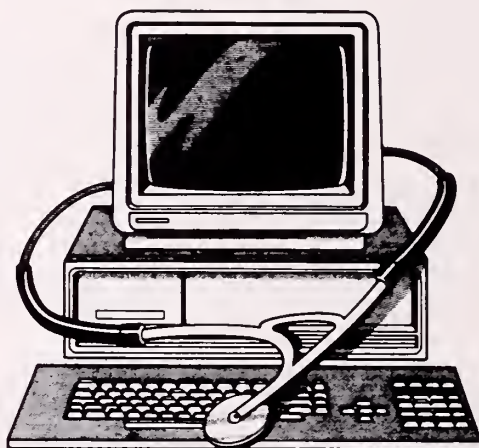
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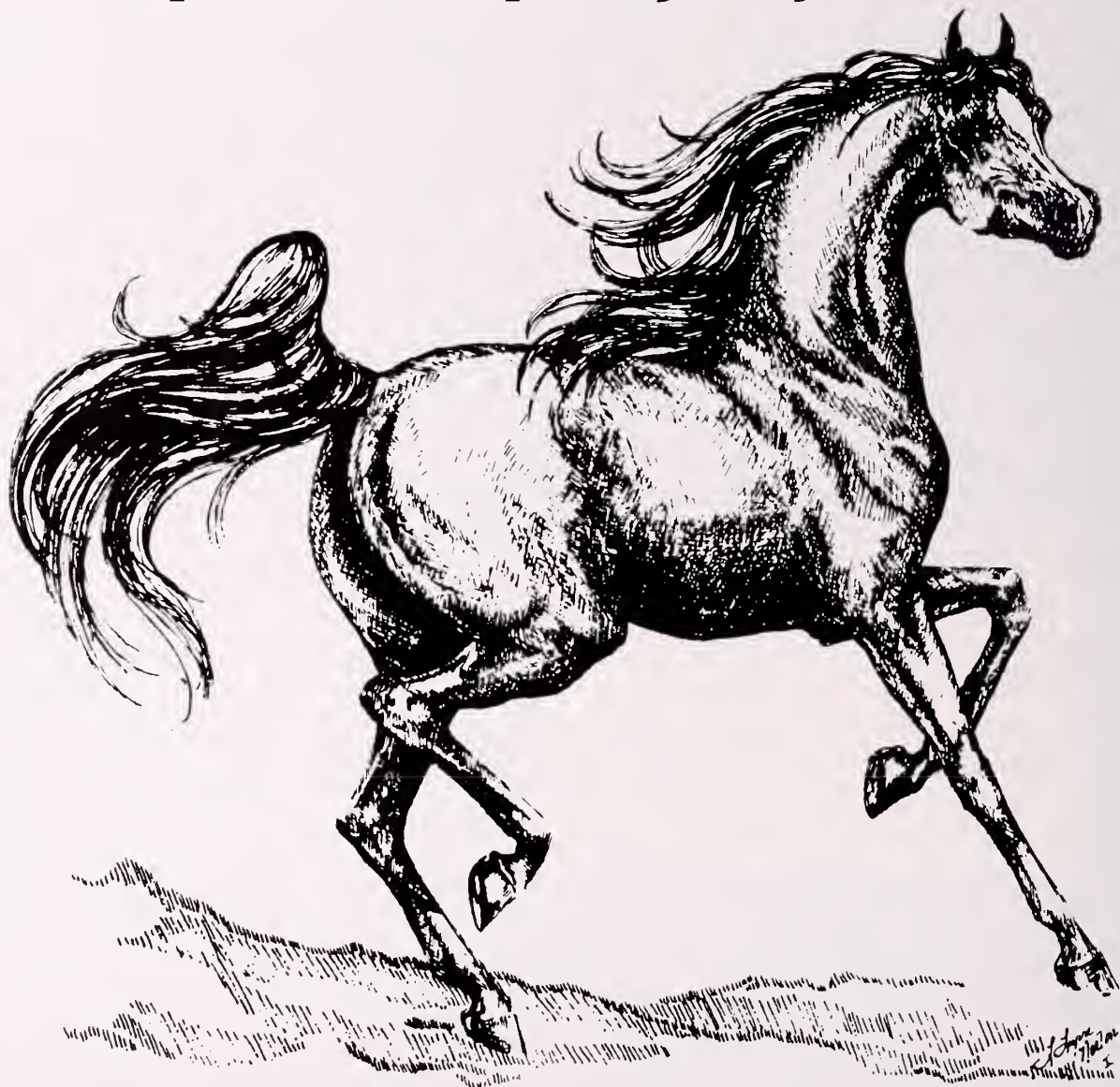
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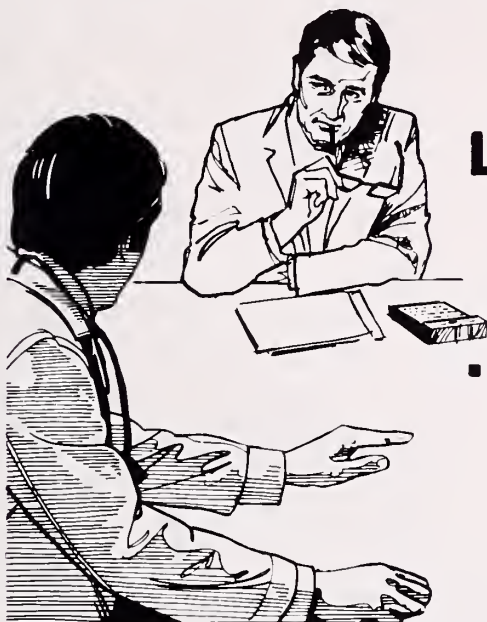
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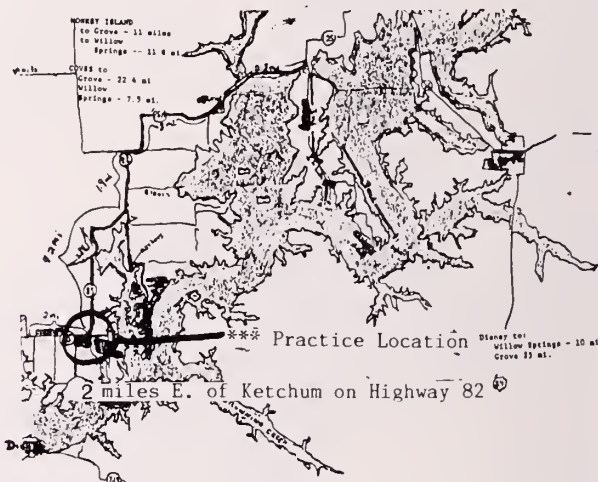
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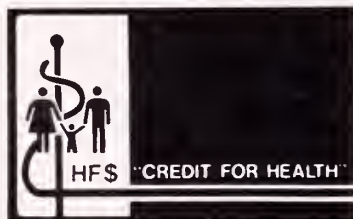
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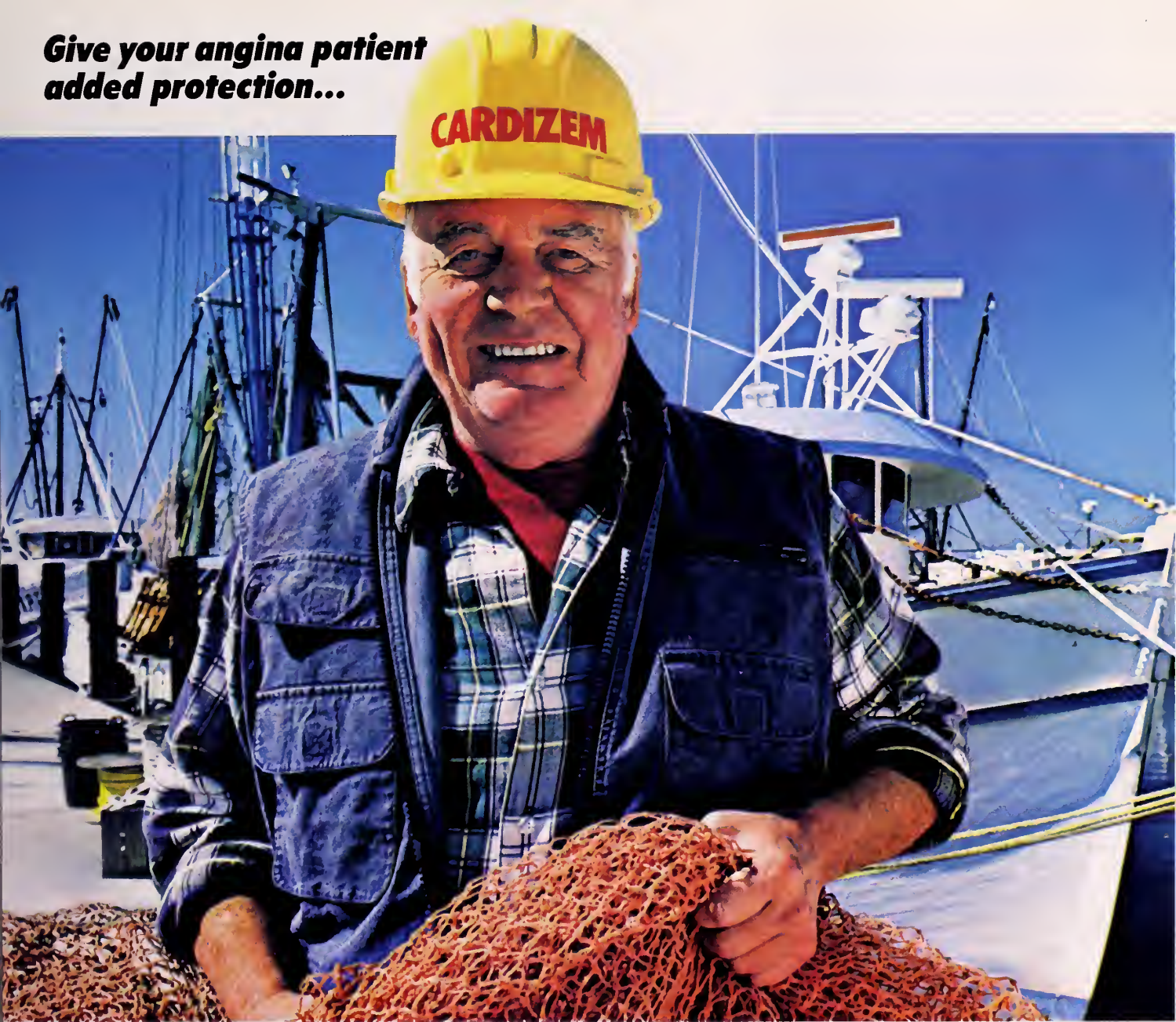
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**\*See Warnings and Precautions.**

*Please see brief summary of prescribing information on the next page.*



# CARDIZEM<sup>®</sup> FEWER SIDE EFFECTS diltiazem HCl/Marion IN ANTIANGINAL THERAPY

60 mg tid or qid

## Brief Summary Professional Use Information

**CARDIZEM<sup>®</sup>**  
(diltiazem HCl) 30 mg and 60 mg Tablets

### CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic)

### WARNINGS

- Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.
- Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). An acute study of oral diltiazem in patients with impaired ventricular function (ejection fraction  $24 \pm 6\%$ ) showed improvement in indices of ventricular function without significant decrease in contractile function (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is limited. Caution should be exercised when using the drug in such patients.
- Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.
- Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

### PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special

subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryonic and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater. There are no well-controlled studies in pregnant women; therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

### ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably associated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular:	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope.
Nervous System:	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor.
Gastrointestinal:	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase.
Dermatologic:	Pellicchia, pruritus, photosensitivity, urticaria.
Other:	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarticular pain, polyuria, sexual difficulties.

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. Issued 11/85. See complete Professional Use Information before prescribing.

**References:** 1. Frishman WH, Chantap S, Goldberger J, et al. Comparison of diltiazem and nifedipine for both angina pectoris and systemic hypertension. *Am J Cardiol* 1985;56:41H-46H. 2. Weiner DA, McCabe CH, Cuffey SS, et al. The efficacy and safety of high-dose verapamil and diltiazem in the long-term treatment of stable exertional angina. *Clin Cardiol* 1985;7:648-653. 3. Pepine CJ, Feldman RL, Hill JA, et al. Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. *Am Heart J* 1983;106(6):1341-1347. 4. Cohn PF, Braunwald E. Chronic ischemic heart disease, in Braunwald E (ed): *Heart Disease. A Textbook of Cardiovascular Medicine*, ed 2. Philadelphia, WB Saunders Co, 1984, chap 39. 5. McCall D, Walsh RA, Frahm ED, et al. Calcium entry blocking drugs. Mechanisms of action, experimental studies and clinical uses. *Curr Probl Cardiol* 1985;10(8):6-80. 6. Chaffman M, Brogden RN. Diltiazem. A review of its pharmacological properties and therapeutic efficacy. *Drugs* 1985;29:387-454. 7. Schroeder JS. Calcium and beta blockers in ischemic heart disease: When to use which. *Mod Med* 1982;50 (Sept):94-116. 8. Shapiro W. Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984;24(Dec):150-159. 9. Jahnsson DL, Lesoway R, Humen DP, et al. Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris: A placebo-controlled, double-blind, randomized, crossover study. *Am J Cardiol* 1985;55:680-687.

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#### 1986 Seminar Schedule\*

<b>August 16</b> , Sat., 10 a.m.-1 p.m.	<b>Oklahoma City</b> OUHSC, East Lecture Hall, Basic Science Building
<b>Sept. 10</b> , Wed., 6-9 p.m.	<b>Lawton</b> Montego Bay Hotel, 1125 E. Gore
<b>Sept. 17</b> , Wed., 6-9 p.m.	<b>Muskogee</b> Holiday Inn, 800 South 32nd
<b>Sept. 24</b> , Wed., 6-9 p.m.	<b>McAlester</b> Holiday Inn, US Hwy 69 Byp South
<b>Oct. 8</b> , Wed., 6-9 p.m.	<b>Enid</b> Ramada Inn, 3005 W. Garriott Road
<b>Oct. 22</b> , Wed., 6-9 p.m.	<b>Oklahoma City</b> Conference Center, 5901 N. May (58th & May)
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## THE LAST WORD

■ **The Oklahoma Occupational Medical Association** will hold its Fall Educational Meeting at the Waterford Hotel in Oklahoma City on November 7 and 8, 1986. The meeting is open to physicians, nurses, physician assistants, and industrial hygienists. For information contact Robert M. Mahaffey, MD, Secretary, at 9912 East 21st Street, Tulsa, OK 74129.

■ **The Oklahoma regional continuing medical education (CME) meeting** of the American College of Physicians (ACP) will be held October 23-25 at Shangri-La Lodge in Afton. For information contact William L. Hughes, MD, FACP, Memorial Professional Building, Suite 200, 13439 North Broadway Extension, Oklahoma City, OK 73114, (405) 752-8780.

■ **Although antibiotic therapy is not routinely prescribed** for children undergoing tonsillectomy, a new controlled study shows it can improve postoperative recovery, according to a report in the June *Archives of Otolaryngology-Head and Neck Surgery*. Steven A. Telian, MD, of University of Pennsylvania School of Medicine, Philadelphia, and colleagues studied tonsillectomy recovery of 85 children: 45 children received an intravenous dose of ampicillin at the time of surgery and continued to receive oral amoxicillin therapy for one week; the other 40 children received a placebo. "Our results indicate that ampicillin sodium/amoxicillin trihydrate therapy is well tolerated and safe in the nonallergic child and is effective in minimizing fever and other troublesome postoperative symptoms, such as pain, lassitude, mouth odor, and poor oral intake after tonsillectomy," the researchers say.

■ **Adverse reactions to bovine collagen implants**, used to correct dermal contour deformities, may depend on the presence of certain antigens and cell-mediated immune responses that are genetically determined, according to a report in the June *Archives of Dermatology*. Evelyn E. Vanderveen, MD, of the University of Michigan Medical School, Ann Arbor, and colleagues measured antigen levels in 25 patients who had varying immune reactions to such implants. "All patients suffering adverse clinical reactions to bovine collagen implants were lacking the HLA-DR4 antigen," the researchers observe. Although skin tests are used to determine sensitivity before implantation, some patients experience adverse reactions even after negative skin tests.

■ **Application forms for research awards by the Oklahoma Affiliate of the American Heart Association** are now available in the affiliate office in the Cameron Building 2915 North Classen, Suite 220, Oklahoma City, (405) 521-9838, or write to Executive Director Rita Matthews, PO Box 11376, Oklahoma City, OK 73136. Deadline for submission of applications is November 1, 1986. Affiliate processing and review will be completed by April 15, 1987, and approved awards activated July 1, 1987. The award categories are research grants in aid, fellowships, and Young Investigator awards.

■ ***Effective Patient Relations*** is the title of the fourth and most recent booklet in the Emergency Medicine Organization and Management Series published by the American College of Emergency Physicians (ACEP). The book discusses improving patient relations by promoting the warm and personal interaction of staff members and physicians with patients, evaluating patient satisfaction, and making the emergency facility's atmosphere more comforting and encouraging. The 20-page publication also discusses special situations such as violent patients, media inquiries, and deaths in the facility. The book is available from the college (\$10 for members, \$15 for nonmembers); orders should be sent to the ACP Distribution Center, PO Box 619911, Dallas, TX 75261-9911, (214) 550-0911. Prepayment is required.

■ **Persons who experience panic disorder, or panic attacks**, marked by feelings of fear and symptoms such as shortness of breath, chest pain, palpitations, faintness, or choking, may also be at risk for temporary elevations in blood pressure, according to a study in the June *Archives of Internal Medicine*. William B. White, MD, and Laurence H. Baker, PhD, of the University of Connecticut School of Medicine, Farmington, report cases of two men in their thirties who had episodes of high blood pressure associated with panic attacks. Both cases improved; one received therapy for stress reduction and the other (who also had high blood pressure at work) was treated successfully with a beta blocker. "Ambulatory blood pressure monitoring is useful in the diagnosis of this disorder and in assessment of treatment outcome," the researchers say. □

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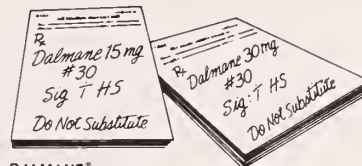
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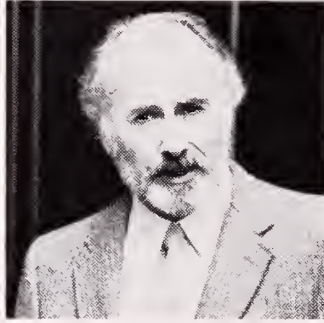
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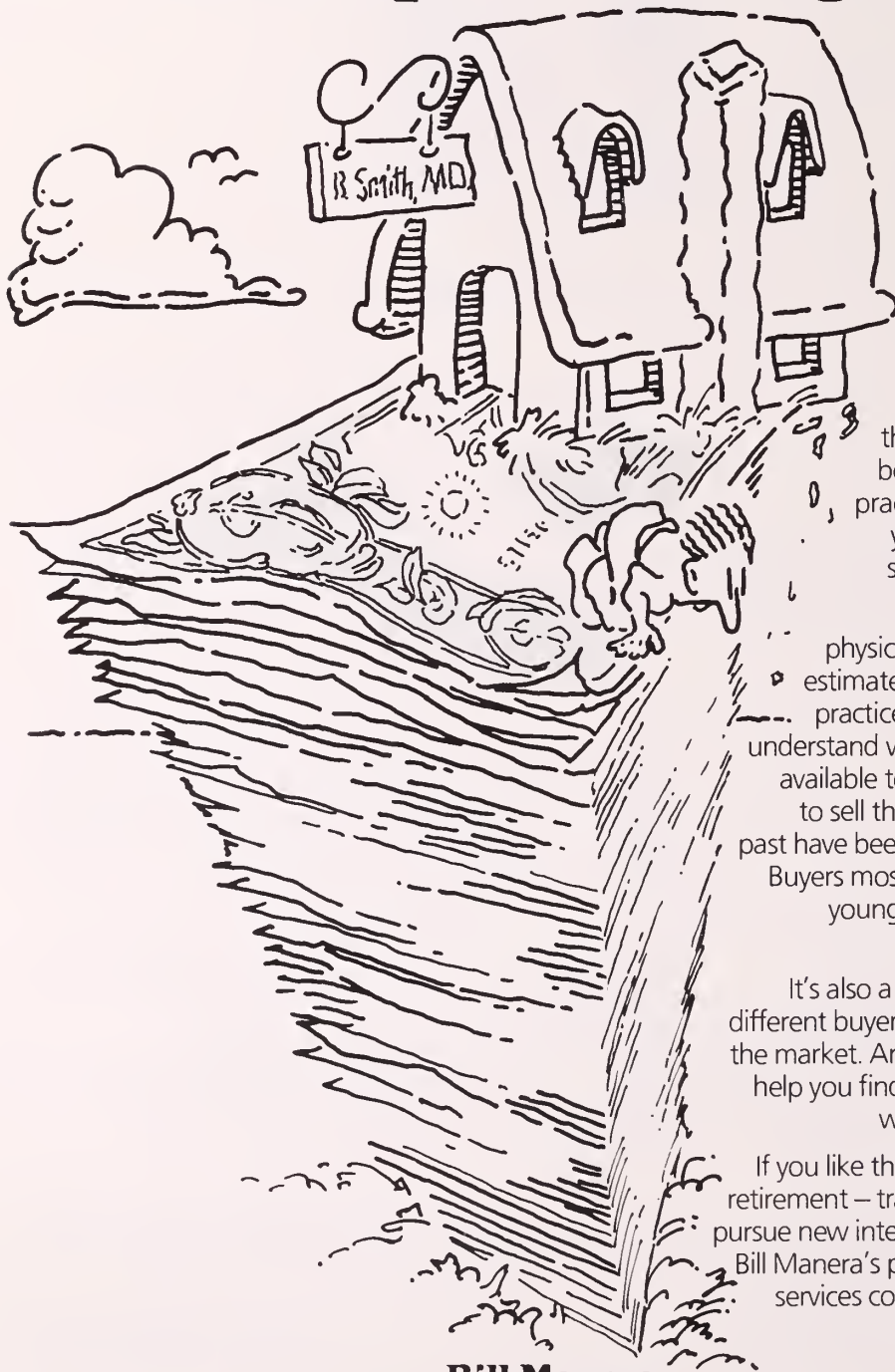
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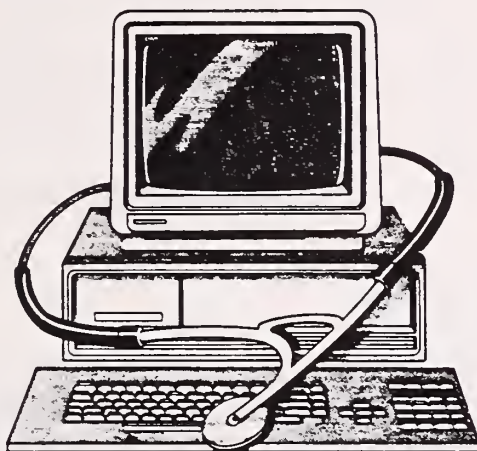
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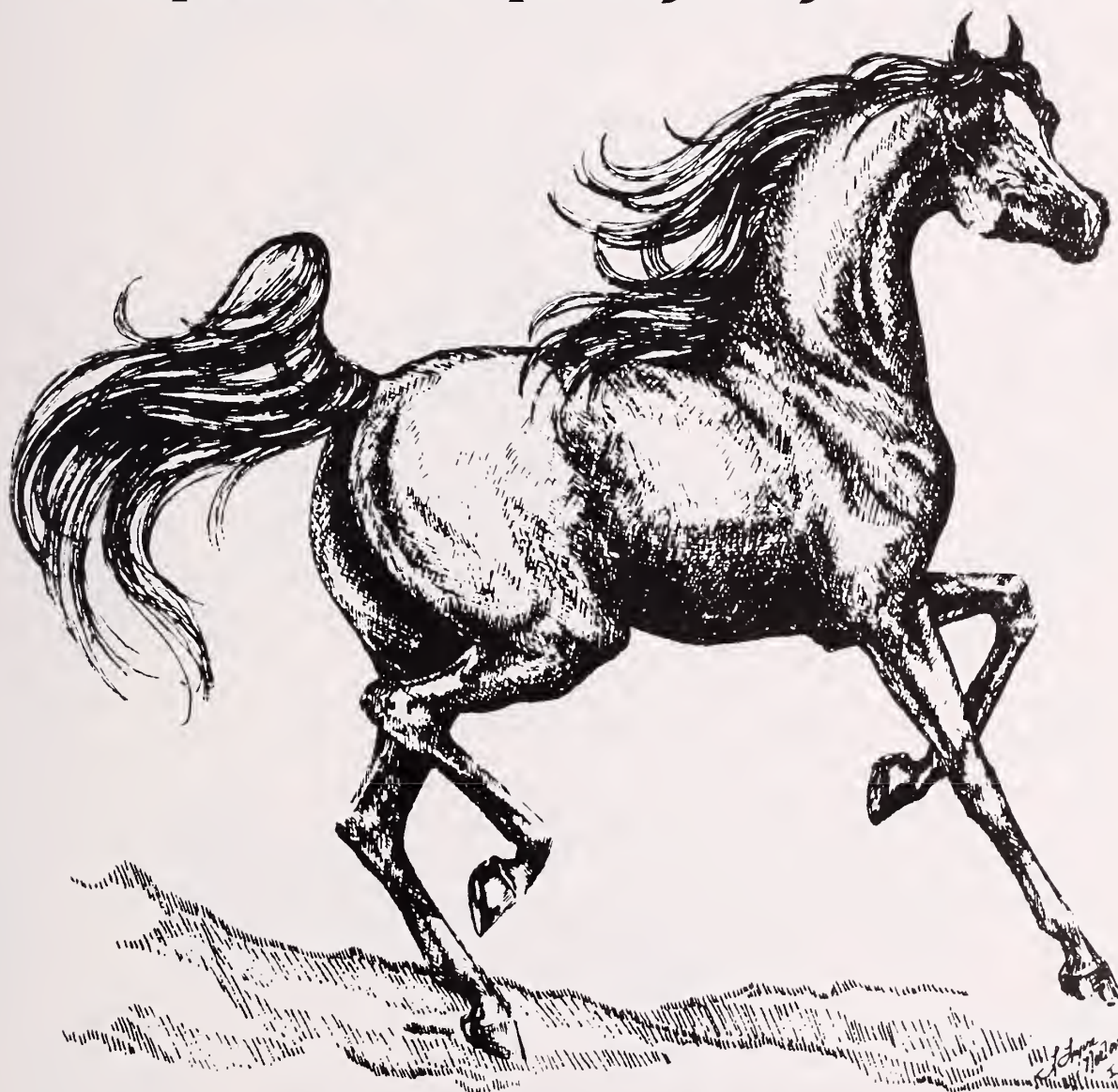


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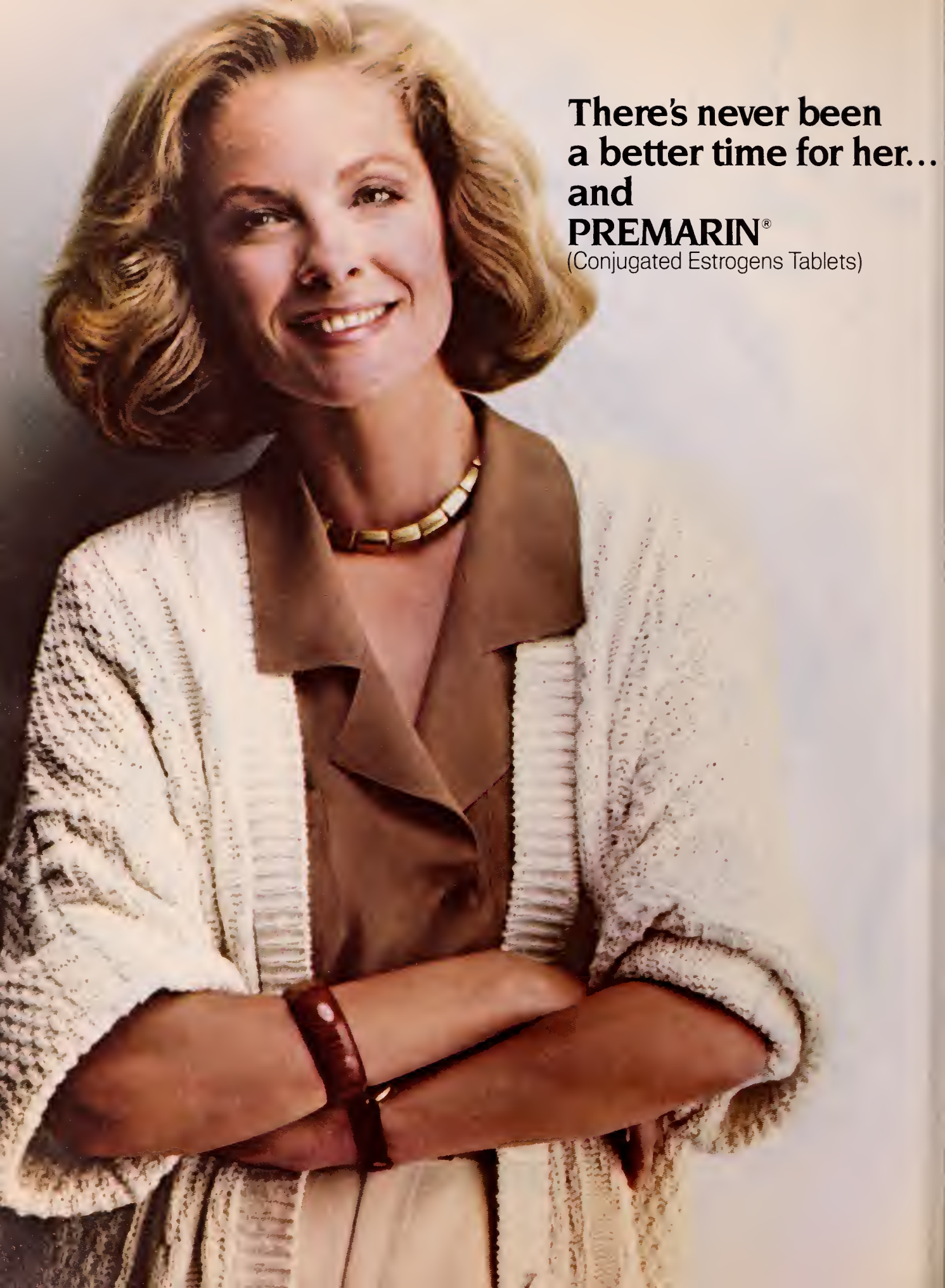
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## **Significantly reduced risk of endometrial hyperplasia**

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\*PREMARIN is indicated for moderate-to-severe vasomotor symptoms.

Please see following page for brief summary of prescribing information.

For moderate-to-severe  
vasomotor symptoms

## PREMARIN® (Conjugated Estrogens Tablets)



0.3 mg 0.625 mg 0.9 mg 1.25 mg 2.5 mg

The appearance of these tablets is a trademark of Ayerst Laboratories.

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION AND PATIENT INFORMATION, SEE PACKAGE CIRCULARS.)

PREMARIN® Brand of conjugated estrogens tablets, USP

PREMARIN® Brand of conjugated estrogens Vaginal Cream in a nonliquefying base

### 1 ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4.5 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration, if therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equiestrogenic doses.

### 2 ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares urine. It contains estrone, equin, and 17 $\alpha$ -dihydroequilin, together with smaller amounts of 17 $\alpha$ -estradiol, equilenin, and 17 $\alpha$ -dihydroequilenin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use:** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy. (See Boxed Warning.) 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, surgery should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with

For atrophic vaginitis

## PREMARIN® (Conjugated Estrogens)

Vaginal  
Cream

0.625mg/g



caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfobromophthaltein retention
  - Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased norepinephrine-induced platelet aggregability
  - Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered
  - Impaired glucose tolerance
  - Decreased pregnandiol excretion
  - Reduced response to methylparathyroid
  - Reduced serum folate concentration
  - Increased serum triglyceride and phospholipid concentration
- As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow; dysmenorrhea; premenstrual-like syndrome, amenorrhea during and after treatment; increase in size of uterine fibromyoma; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme, erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria, edema, changes in libido.

**ACUTE OVERDOSSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

### DOSEAGE AND ADMINISTRATION:

PREMARIN® Brand of conjugated estrogens tablets, USP

- Given cyclically for short-term use only. For treatment of moderate to severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.
- Given cyclically. Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

PREMARIN® Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three- to six-month intervals.

Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

### References:

- Whitehead MJ, Townsend PT, Pryse-Davies J, et al. Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605. 2. Paterson MEL, Wade-Evans T, Sturdee DW, et al. Endometrial disease after treatment with estrogens and progestogens in the climacteric. *Br Med J* 1980;280:822-824. 3. Magos AL, Brincat M, Studd JWW, et al. Amenorrhea and endometrial atrophy with continuous oral estrogen and progestogen therapy in postmenopausal women. *Obstet Gynecol* 1985;67:496-499. 4. Whitehead MJ, Lane G, Siddie N, et al. Avoidance of endometrial hyperstimulation in estrogen-treated postmenopausal women. *Semin Reprod Endocrinol* 1983;1:41-52. 5. Barnes RB, Roy S, Lobo RA. Comparison of lipid and androgen levels after conjugated estrogen or depo-medroxyprogesterone acetate treatment in postmenopausal women. *Obstet Gynecol* 1985;66:216-219.

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## Sick Jokes

I'm sure you've heard the one about the man who responded to a bit of news with mixed emotions. The news was that his mother-in-law had driven off a cliff in his brand new Rolls Royce. A sick joke, but appropriate to describe my mixed emotions upon hearing that OFPR's contract with HCFA will not be renewed automatically, if at all.

Philosophically opposed to the form and function of peer review as currently sponsored by the bureaucratic sovereignty, I do support the objectives of peer review. Systems designed to regulate utilization of resources and promote high quality health care are essential to the preservation and strength of our profession. They deserve and enjoy the conscientious support of the great majority of physicians.

Well-intentioned as it may have been, the decision to create our own provincial peer review (a major misnomer) organization was unwise at best. We knew we would be entering a contract with an unpredictable, unmanageable party whose motives were ill-defined if not downright suspicious.

Among the several arguments advanced in support of creating our own review organization was the old tooth-worn saw that says, "If we don't do it to ourselves, someone else will do it to us." That premise

has resulted in so much self-mutilation in the past thirty-five years, we've hardly anything left to cut off.

Well, we've been doing peer review to ourselves now for a number of months. As far as I can tell, we've been doing it with a high degree of efficiency and effectiveness. We have kept our part of the bargain (another major misnomer) and acted in good faith. True, we have — to some extent at least — served as contract executioners, but that was part of our agreement. We have, at least, exercised some precision and discretion in selecting those to be punished.

It seems, however, our contractors had something else in mind. They have declared we have not done the job they wanted done and are planning to replace us with some imported guns. And I hope they do. If I am to be executed, I prefer that my executioner be an alien stranger rather than a familiar colleague.

We should have known better. Or, perhaps the feds should have repeated the lines of another sick joke when we signed their contract. As the victim shook hands with his executioner, he whispered, "I think I should warn you. Ours will not be an enduring friendship."

—MRJ

Fellow Physicians:

As most of you know by now, HCFA has not renewed our Oklahoma PRO contract. Whether or not we liked this contract, we have been forced to accept its provisions and have elected to cooperate.

Now, however, HCFA is trying to find some other review organization to take over this program or at least to force our PRO to increase the sanctions and restrictions applicable to Medicare patients.

It is my opinion — and in this instance there was near unanimous agreement among our state officers and delegates — that we should not allow our own PRO to restrict any further the health care that the



elderly receive. Therefore, we will not accept any alteration of our present program in any significant fashion. If our government then contracts with some other source to do their hatchet work on care to the elderly, we can protest this in the open; we can place the responsibilities for these limitations of medical care and penalties to physicians where they properly belong.

I hope I have your support in this position.

A handwritten signature in dark ink. The signature is written in a cursive style and reads "Norman L. Dunitz, MD". The "MD" is written in a slightly larger, more formal script at the end of the signature.

Norman L. Dunitz, MD

# Cat-Scratch Disease: A View from the Oklahoma City Clinic

CLIFFORD G. WLODAVER, MD, and HAL VORSE, MD

**Cat-scratch disease, one of the many causes of lymphadenopathy, is self-limiting and benign but nevertheless frustrating and anxiety-laden since there are no definitive tests to confirm the diagnosis.**

Cat-scratch disease is a relatively common cause of regional lymphadenopathy. Because there are no definitive laboratory findings, the diagnosis relies on clinical acumen. Major diagnostic criteria include unifocal lymphadenopathy, exposure to cats, and the absence of other lymphadenopathy-causing disease. Other helpful diagnostic criteria include the identification of an inoculation site on the skin, pathologic findings from a skin and/or node biopsy which are consistent with the diagnosis, failure to respond to empiric antibiotics, and the picture of a relatively mild, self-limited disease. The presence of microorganisms seen on special stains has recently been reported. Our laboratories are presently investigating the staining procedure. We have reviewed the Oklahoma City Clinic experience with this disease from May 1982 to October 1985. Our findings are shown in Table 1.

## Discussion<sup>1-4</sup>

Among the multiple causes of lymphadenopathy, cat-scratch disease is self-limiting and benign, but frustrating and anxiety-laden since there are no defini-

tive tests to confirm the diagnosis. It is defined clinically by regional adenopathy, a cat scratch or at least cat exposure, and the absence of any other lymphadenopathy-causing diseases. The disease has been seen in every age group but is most prevalent in children. Eighty-seven percent of our patients have been sixteen years old or younger. Men and women are equally susceptible. Veterinarians are obviously predisposed. Most cases occur in the fall and winter, and the disease has been reported from most parts of the world. Our impression is that there is an abundance of cases occurring in Oklahoma, but we have no epidemiologic data to substantiate this.

**Lymphadenopathy  
understandably evokes  
anxiety and fear  
in the patient.**

The process begins with exposure to a cat in at least 90% of the cases, with kittens being the major culprits. In some reports, dogs have been associated with the disease as well. In some series, up to 10% of cases have had no known contact with either cats or dogs. Most series report scratches in approximately 65% of cases. Interestingly, only 26% of our patient population could recall a scratch, although 96% of

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**Table 1. — Oklahoma City Clinic Experience with Cat-Scratch Disease**

<b>Age:</b> under 16 years old range: 28 months—50 years	20/23	87%
<b>Sex:</b> 10 males, 13 females		
<b>Cat Exposure:</b>	22/23	96%
<b>Cat Scratch*:</b>	6/23	26%
<b>Inoculation Site Lesion:</b>	12/23	52%
<b>Nodes:</b>	23/23	100%
Axillary	12/23	52%
Inguinal <sup>†</sup>	3/23	13%
Epitrochlear	3/23	13%
Supraclavicular	2/23	9%
Cervical	3/23	13%
Occipital	1/23	4%
<b>Constitutional Symptoms (fever, malaise):</b>	4/18	22%
<b>Skin Test Positive:</b>	4/5	80%
<b>Surgical Management:</b>		
None	13/22	59%
Percutaneous aspiration	6/23	26%
Biopsy	2/23	9%
Excision	2/23	9%
Incision & Drainage	0/23	0%
<b>Antibiotics<sup>‡</sup>:</b>	9/23	39%
<b>Other Diseases<sup>§</sup>:</b>	0/23	0%
<b>Outcome:</b> All lesions resolved	23/23	100%

\*Most patients and family of children were unable to recall a specific cat scratch.

<sup>†</sup>One patient had bilateral inguinal adenopathy. All other patients had unifocal adenopathy.

<sup>‡</sup>Cephalexin, penicillin, dicloxacillin, and erythromycin. Antibiotics were not associated with clinical improvement.

<sup>§</sup>When obtained, cultures of surgical specimens for bacteria, fungi, and mycobacteria were negative. Likewise, PPD skin tests were negative and serology for mononucleosis, toxoplasmosis, and tularemia were negative.



**Fig 1.**—Primary lesion on the finger of a child who was scratched by a young cat 10 days earlier.

these patients had had close contact with cats and 52% had an inoculation site lesion. The animals themselves were not ill.

A papule often occurs at the inoculation site within 7 to 14 days after the scratch is received. It is always distal to the lymphadenopathy, usually on the line of the scratch. Although this finding may be overlooked, it can be found in greater than 90% of case if searched for carefully. The lesion is a faintly erythematous papule 2mm to 5mm in diameter, often with a layer or two of onionskin peeling toward its center. We found such a lesion in 12 (52%) of our patients. The skin lesion generally resolves within 10 to 20 days. The pathology of the inoculation site skin lesion can support the diagnosis of cat-scratch disease. Since a skin biopsy is a relatively simple and benign procedure, we feel this is a sound temporizing maneuver while continuing close clinical observation.

Several days to several weeks (the incubation period is 3 to 30 days, with an average of 7 to 12 days) after the cat scratch/exposure, nodes proximal

to the inoculation site become large and tender. The lymphadenopathy is generally isolated to one node or to one anatomic area, usually the upper extremity. Axillary adenopathy occurred in 52% of our patients, inguinal adenopathy in another 13%. The nodes may become fluctuant in approximately 25% of cases. The lymphadenopathy resolves in 6 to 8 weeks, although rarely it may persist for up to a year.

Constitutional symptoms including malaise, headache, and myalgias can occur in up to 50% of cases. Fever, which is usually low grade, occurs in 25% to 30% of patients. The constitutional symptoms generally resolve within two weeks. Atypical presentations and complications are unusual, occurring in less than 5% of cases. These include Parinaud's oculoglandular syndrome, erythema nodosum, encephalitis, transverse myelitis, thrombocytopenic purpura, erythema marginatum, osteomyelitis, pneumonitis, and splenomegaly.

The pathology of the inoculation site and node show similar findings. A central necrotic area surrounded by lymphocytes, giant cells, and histocytes



**Fig 2.**—Enlarged fluctuant axillary lymph node of a child who was scratched on the hand by a kitten.



**Fig 3.**—Firm, nonfluctuant slightly tender preauricular lymphadenopathy in a child who was scratched on the face 1 month earlier; primary lesion had resolved.

is typical. The nodes show evolution through stages of follicular hyperplasia, granuloma, and stellate microabscesses, and all stages may be present in the same node. While consistent with the diagnosis of cat-scratch disease, these findings are not specific and can also be seen in tularemia and lymphogranuloma venereum.

Recently, microorganisms have been reported in the biopsied nodes and skin lesions when stained by Wartin-Starry silver impregnation method. The Medical Arts Laboratory in Oklahoma City is presently reviewing the staining procedure. If organisms are indeed present and can be seen, this would have obvious diagnostic implications.

The cat-scratch disease skin test has been recommended as being diagnostically useful. However, we feel this test is not well standardized, certainly not to the degree of other skin tests such as those for tuberculosis. The product is not approved by the Food and Drug Administration (FDA). It is not commercially available and is difficult to obtain. It is derived from a soup of nodes from patients having cat-scratch

disease. There is at least a theoretical concern regarding its safety, especially because the acquired immunodeficiency syndrome (AIDS) is often associated with lymphadenopathy. All things considered, we no longer employ this test.

Cat-scratch disease is a diagnosis of exclusion, arrived at after other causes of lymphadenopathy have been excluded. However, the vigor of the evaluation to exclude other diseases should be tempered by the relatively common occurrences of cat-scratch disease itself. When cat-scratch disease is suspected, we feel that the mainstay of management is clinical observation and reassurance. This plan is often difficult to follow since lymphadenopathy understandably evokes anxiety and fear in the patient and family. It is often difficult to decide if and when to obtain a lymph node biopsy. If the diagnosis of cat-scratch disease is strongly suspected on clinical grounds, we try to avoid or at least postpone the biopsy, waiting for spontaneous resolution of the node. As previously noted, this usually occurs within six to eight weeks. On the other hand, persistent lymphadenopathy, se-



Fig 4.—Erythema nodosum in a child with submandibular cat-scratch adenitis.

vere constitutional symptoms, other findings suggesting perhaps more serious disease, or anxiety on the part of the patient and family may make lymph node biopsy unavoidable.

Aspiration of the node can be an intermediate step between simple observation and biopsy. It is

therapeutic for the patient whose node is fluctuant and tender. Incision and drainage is not recommended since this procedure can be complicated by the formation of a sinus tract and prolonged drainage.

Although cat-scratch disease is probably an infectious disease, Koch's postulates have not been fulfilled. Antibiotics are not felt to be helpful. Accordingly, the mainstay of therapy remains symptomatic, with close clinical observation and reassurance. □

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## Coming in October . . .

Manuscripts being considered for publication in October include a discussion of PCBs in our environment, a commentary on the use of trypsin in treating hyaline membrane disease, and a look at the health care provider's role in drug screening. A report on a bacteria filter for volume ventilators is also being planned.

# Breast Cancer Detection: Is There a Commercial Mania?

RALF E. TAUPMANN, MD

**Early detection of breast cancer is a must in order to improve the survival and cure rates. This article considers the many diagnostic modalities available and tries to provide a better understanding of those which are most accurate, truly necessary, and cost effective.**

Numerous lay magazine articles, newspaper stories, and television advertisements report another, "new and better" modality for breast cancer detection. It is the purpose of this article to define those modalities which have stood the test of time and are really necessary and cost effective in the detection of breast cancer.

Breast cancer in women is now the second leading cause of female deaths, being surpassed only by lung cancer in 1985. One hundred and nineteen thousand women will develop cancer of the breast, and 39,000 will die from this dreaded disease this year. One of every eleven women or nine percent of all women will develop breast cancer. Early detection of breast cancer many result in more reasonable survival statistics. An increased judicious effort toward breast cancer detection should be made.<sup>1</sup>

## Breast Self-Examination

Women should be taught breast self-examination because 75% of all breast cancers are detected by women themselves. Only 10% of women actually practice

breast self-examination. Public education should be stressed. In a recent study done on plastic mammary models with four "known lumps" implanted within the model, lay women and physicians were asked to locate these lumps by palpation. Women who had a formal training session first fared much better than physicians in finding these lumps.<sup>2</sup> If women would become more familiar with their own breasts, earlier detection would probably lead to better survival statistics. It should be kept in mind that the lumps generally found by women are 2-3 cm in size, and in 50%-60% of these, axillary metastases are present.<sup>3,4</sup>

## Mammography

Mammography has proven to be the gold standard in detection of early breast cancer. Not only was this documented by the Health Insurance Plan of Greater New York (HIP) study, but also by the Breast Cancer Detection Demonstration Project (BCDDP). The latter ran from 1974 to 1981 and was sponsored by the American Cancer Society and the National Cancer Institute. Twenty-nine centers throughout the United States each screened 10,000 self selected women age 31-74 years, with physician examination and mammography. Some sites also did thermography. Oklahoma City did have such a center and participated in the project. Conclusions from data of the BCDDP were that mammographic screening can detect breast cancer at an early non-palpable stage. Improved survival from effective screening is a reasonable expectation.<sup>5</sup>

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Whether film/screen mammography or xeromammography is used, is a matter of preference of the examiner, provided he or she is thoroughly trained in either modality, employs rigid quality control techniques, and uses state-of-the-art equipment. The author prefers xeromammography, having had extensive training and experience in that modality.<sup>6-8</sup>

Radiation doses from both modalities are so low with the newest dedicated mammographic equipment that fear of radiation by the patient should not be a limiting factor. The benefits of mammography far outweigh the risks of minute amounts of radiation.<sup>9</sup> Women with known lumps in one breast should have a baseline mammogram to rule out other hidden lesions in the same breast, as well as unsuspected, nonpalpable lesions in the opposite breast. The American Cancer Society guidelines on mammography are based on the BCDDP study, prove valid and should be followed.<sup>10-12</sup> These recommendations are:

1. All women should be taught proper breast self-examination by age 20 years and should have an annual physical examination of the breast after age 35 years.
2. Baseline mammogram should be obtained by age 40 years. An earlier age is preferable in high risk patients.
3. Subsequent mammographic examinations at one to two year intervals as determined by analysis of physical and mammographic findings and other risk factors.
4. Annual mammography for all women over age 50 years.

## Ultrasound

The use of ultrasound imaging of the breast has been described in numerous articles in the past. Most conclude that it should be used as an adjunct to mammography. Differentiation between cyst vs. solid mass is its main function and has, on occasion, given the final answer when the examiner had difficulty deciding whether a mass was cystic or solid, and where simple and much less expensive needle aspiration was either impractical or did not yield diagnostic material. Ultrasound does not, however, localize the tiny calcifications often associated with malignancy and cannot, in most cases, differentiate benign from malignant solid tumors.

Ultrasound seems useful in relatively dense breasts of women under age 40 years, where potentials for false negatives are higher and both physical examination and mammography prove difficult. Most

examinations can be performed with a hand-held unit, having transducer frequency of 5MHz or above.<sup>13-17</sup> Automated ultrasound units are expensive and have not proven effective in screening.

## Thermography/Thermology

Thermography does not have sufficient sensitivity to be a substitute for mammography in diagnosis or screening. Thermography does not utilize radiation, but is a heat-sensing technique. It has not proven sensitive enough to be used as a diagnostic tool, especially in the hands of individuals unfamiliar with the various heat-sensing models on the market. It should definitely not be used as a sole means of breast cancer detection.<sup>18-22</sup>

## Computerized Axial Tomographic Scanning

Computerized axial tomographic (CAT) scanning of the breast with specially designed models has been tried. The patient was placed prone with the breasts hanging into specially designed wells. Scanning was performed twice, pre and post iodine infusion. The double radiation dose and the prohibitive cost were limiting factors. The initial cost of the equipment was also a limiting factor in cost accounting this procedure for mass screening. Clear-cut differentiation between benign or malignant tissue was also lacking in some cases. A regular CAT scanner has proved useful in isolated cases, when localization of small tumors was only seen on one view at mammography. The same principle for localization as for fine needle aspiration is used; a small, fine wire is left in place for subsequent surgical removal of adjacent tissue surrounding the wire.<sup>23,24</sup>

## Magnetic Resonance Imaging (MRI)

Magnetic resonance imaging is a non-invasive technique that does not utilize ionizing radiation. This would be of benefit, but presently no clear-cut distinction between cancerous and normal tissues can be conclusively demonstrated. Future refinements in spectroscopy imaging may make such a differentiation possible. MRI is also not cost effective at this time.<sup>25</sup>

## Diaphonography

Diaphonography or translumination bases its concept on preferential infrared absorption by nitrogen-rich compounds. Malignant cells are observed to have a higher nitrogen content. Since the human eye cannot detect infrared light, special infrared sensitive

photographic film is utilized. More recently, infrared sensitive television cameras with standard television monitors have been marketed, which permit real time viewing of the infrared images. Not enough data have been accumulated to state positively that this modality is effective for routine screening in breast cancer detection.<sup>26,27</sup>

## Digital Subtraction Angiography

There is very limited experience with this technique. As a technique, vascular enhancement imaging of tumors is well known. More data and experience are needed about this application. The procedure is invasive and there is an increased radiation exposure to the patient. Cost effectiveness is also an unknown.<sup>28,29</sup>

## Conclusion

If we are to see significant improvements in the statistics of early breast cancer detection and subsequent cure, we must employ the best proven modalities available. Breast self-examination, regular physical checkups, and mammography, when appropriate, have stood the test of time and are indeed worthwhile. The results of several significant, large studies support this conclusion.<sup>30</sup> Other imaging techniques should be used judiciously and only when deemed necessary. Cost should be kept as low as possible in order to make screening readily available to all women. The American Cancer Society Guidelines have proven merit and should be followed. □

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# Prevalence of *Legionella pneumophila* Infection in Oklahoma

PEGGY J. GUTHRIE, PHD; STANLEY L. SILBERG, PHD; CHARLES H. LAWRENCE, PHD

The relatively high prevalence of asymptomatic infection among the Oklahoma population surveyed indicates rather frequent environmental exposures to *Legionella pneumophila*.

Legionellosis, a disease which may vary from a mild febrile infection to a less common but more serious pneumonia, was first recognized in July 1976 following an American Legion convention in Philadelphia where 182 Legionnaires became ill; 29 of them died from the unknown disease. Six months later, a team headed by McDade<sup>1</sup> isolated the agent, an aerobic gram-negative bacillus, from the lung of a Legionnaire who had died. The name proposed for the previously unrecognized species was *Legionella pneumophila*<sup>2</sup> and the illness became commonly known as Legionnaires' disease.

The epidemic outbreaks apparently have involved a common source and have probably been airborne rather than transmitted directly from person to person.<sup>3</sup> Systems such as air conditioning cooling towers, evaporative condensers, and steam turbine condensers have yielded the organism,<sup>4,5</sup> thus implicating water as either an environmental source or a vehicle.<sup>6</sup> Other sources of *L. pneumophila* have yet to be confirmed, but soil exposure has been a common factor in most of the reported epidemics.

Table 1. — Distribution of Antibody Titers to *Legionella pneumophila* Among Oklahoma Blood Institute Volunteers, 1981

Antibody Titer	Number Surveyed*	Prevalence Rate, (Per 100)
<1:16	182	37.1
1:16	44	9.0
1:32	94	19.1
1:64	64	13.0
1:128	70	14.3
1:256	20	4.1
1:512	9	1.8
1:1024	2	0.4
1:2048	6	1.2
Total surveyed	491	
Total positives†	171	34.8

\*500 serums were tested; demographic data were missing for 9 serums.

†Titers <1:64 were considered seronegative (not infected).

Titers ≥1:64 were considered seropositive (infected).

Exposure to this agent may not be as rare as events like the Philadelphia outbreak would indicate, and infection may not be limited to epidemic situations. There is now evidence that the disease has been present for years in many countries and that most cases of infection appear to be mild or even subclinical, without specific diagnostic signs or

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Table 2. — Distribution of Antibody Titers to *Legionella pneumophila* Among Oklahoma Blood Institute Volunteers, by Age, 1981

		Age Group					
		<20	20-24	25-34	35-44	45-54	>54
#surveyed	<1:16	16	42	55	33	17	19
%		32.7	38.2	38.2	43.4	25.4	42.2
#surveyed	1:16	5	7	11	9	10	2
%		10.2	6.4	7.6	11.8	14.9	4.4
#surveyed	1:32	9	19	31	13	12	10
%		18.4	17.3	21.5	17.1	17.9	22.2
#surveyed	1:64	5	22	14	6	10	7
%		10.2	20.0	9.7	7.9	14.9	15.6
#surveyed	1:128	8	15	23	9	10	5
%		16.3	13.6	16.0	11.8	14.9	11.1
#surveyed	1:256	5	5	5	2	2	1
%		10.2	4.5	3.5	2.6	3.0	2.2
#surveyed	1:512	1	0	1	4	3	0
%		2.0	0	0.7	5.3	4.5	0
#surveyed	1:1024	0	0	1	0	0	1
%		0	0	0.7	0	0	2.2
#surveyed	1:2048	0	0	3	0	3	0
%		0	0	2.1	0	4.5	0
Total surveyed*		49	110	144	76	67	45
Total positive†		19	42	47	21	28	14
% positive		38.8	38.2	32.6	27.6	41.8	31.1

\*500 serums were tested; demographic data were missing for 9 serums.  
†Titers <1:64 were considered seronegative (not infected).  
Titers ≥1:64 were considered seropositive (infected).  
Kruskal-Wallis: H = 6.0; p = 0.3.

symptoms. Given that soil and/or water are involved in the transmission, it is reasonable to assume that the organism is widely distributed in nature and, therefore, exposure is widespread among the general population. Such exposure would lead to some clinical infections as shown by the detection of sporadic cases; however, many infections would remain undetected but result in active immunity due to the production of *L pneumophila* antibodies. Edson et al<sup>7</sup> estimated a prevalence rate for *L pneumophila* antibodies of 22% for the US population and Foy et al<sup>8</sup>, who reported the incidence of Legionnaires' disease to be 0.4/10,000 to 2.8/10,000 persons/year for a Seattle group, stated that the infection has been quite common nationwide.

Legionnaires' disease is known to occur in Oklahoma, as more than 20 cases have been reported<sup>9</sup> since the Philadelphia outbreak; however, seropositive evidence of infection in the general population is lacking. The purpose of this study was to determine the prevalence of antibodies to *L pneumophila* in sera

from selected persons in Oklahoma. The presence of such antibodies would indicate past or present infection, although not necessarily clinical disease, and could ultimately lead to a better understanding of the transmission of the causative organism and the incidence of the disease.

## Methods and Procedures

The human sera utilized in this study were provided by the Oklahoma Blood Institute, a nonprofit regional center with several donor centers in the state. The institute supplies blood and blood components to patients in hospitals serviced by the regional center and cooperates through the American Association of Blood Banks' clearing house to provide blood for patients hospitalized outside the institute's service area.

The volunteer donor group which was composed of 300 men and 200 women ranging in age from 14 to 65 years, was drawn from 17 Oklahoma counties and represented rural areas and towns whose popula-

Table 3. — Distribution of Antibody Titers to *Legionella pneumophila* among Oklahoma Blood Institute Volunteers, by Age and Sex, 1981

Age	Men			Women			Total		
	Number		% Pos	Number		% Pos	Number*		% Pos
	Pos <sup>†</sup>	Surveyed		Pos <sup>†</sup>	Surveyed		Pos <sup>†</sup>	Surveyed	
< 20	14	29	48.3	5	20	25.0	19	49	38.8
20-24	19	62	30.6	23	48	47.9	42	110	38.2
25-34	34	90	37.8	13	54	24.1	47	144	32.6
35-44	10	49	20.4	11	27	40.7	21	76	27.6
45-54	15	37	40.5	13	30	43.3	28	67	41.8
> 54	10	26	38.5	4	19	21.1	14	45	31.1
Total	102	293	34.8	69	198	34.8	171	491	34.8

\*500 serums were tested; demographic data were missing for 9 serums.  
<sup>†</sup>Infection is considered an antibody titer  $\geq 1:64$ .  
Males only:  $\chi^2(5) = 8.4$ ;  $p = 0.16$   
Females only:  $\chi^2(5) = 10.18$ ;  $p = 0.07$   
Males and Females:  $\chi^2(5) = 4.6$ ;  $p = 0.4$

tions varied from 12,600 to over 500,000. Each donor was free of obvious illness and was considered to have had an *L pneumophila* exposure experience representative of the county in which he or she resided. The blood samples, which were collected during June and July, 1981, were allowed to clot at 5°C before being centrifuged, and the serum was stored in 5-mL aliquots at -20°C at the institute for approximately two weeks. All testing was completed within four weeks after initial collection from donors.

The indirect fluorescent antibody (IFA) procedure recommended by Wilkinson et al<sup>10</sup> and revised by the

ter 2072 and mercury vapor lamp 2055. Each serum was initially tested at dilutions of 1:16 through 1:128, with specimens which tested positive at the 1:128 dilution being further diluted to 1:2048 to obtain a final titer. The IFA test was considered positive if the bacteria produced a 1<sup>+</sup> staining intensity<sup>11</sup> and negative in the absence of a yellow-green fluorescence. Antibody titers were recorded as the reciprocal of the highest dilution producing a positive test.

A titer  $\geq 1:64$  was considered a positive test for IFA antibodies to *L pneumophila* and was accepted as indicating a past or present infection but not necessarily clinical disease. The lower titers of 1:16 and 1:32 were excluded because the IFA procedure utilizing the particular antigen described was relatively new; therefore, sensitivity and specificity were inconclusive.

Descriptive statistics such as frequencies and means were used to summarize and compare the data, and the Kruskal-Wallis one-way analysis of variance<sup>12</sup> and the chi-square test were utilized for testing hypotheses at the 0.10 level of significance. Point prevalence rates were computed for comparing the counties included in the study.

## Results

Of the 500 serum samples collected, demographic data were not available for nine; therefore, only 491 individuals were included in the analysis. The distribution of serum IFA titers against *L pneumophila* subgroups 1, 2, 3, and 4 (Table 1) indicates that the overall prevalence rate of infection among the Okla-

## A rural-urban difference, probably related to soil contact, appears to exist.

Centers for Disease Control<sup>11</sup> was employed in this study. This test uses a polyvalent antigen composed of serogroups 1, 2, 3, and 4 with a fluorescein conjugate that detects IgG, IgM, and IgA immunoglobulins. In addition, normalized yolk sac was used in the initial 1:16 dilution in order to absorb undefined nonspecific factors that occur in some sera.<sup>10</sup>

All slides were cover-slipped with buffered glycerol mounting medium and read at 1000 $\times$  with an American Optical H120 fluorstar utilizing fluorclus-

Table 4. — Distribution of Antibody Titers to *Legionella pneumophila* among Oklahoma Blood Institute Volunteers, by County of Residence

County	Range of Antibody Titers	Number of Seropositives*	Total Surveyed <sup>†</sup>	Prevalence Rate (Per 100)
Beckham	0	0	1	0
Blaine	1:128	1	4	25.0
Caddo	1:64-1:512	31	93	33.3
Comanche	1:64-1:2048	48	104	46.2
Cotton	1:32	0	1	0
Garfield	1:64-1:512	40	126	31.7
Garvin	1:16	0	3	0
Grady	1:64-1:2048	15	31	48.4
Grant	1:64	1	1	100.0
Jefferson	0-1:128	1	2	50.0
Kiowa	1:64-1:256	4	13	30.8
Major	1:32	0	1	0
Oklahoma	1:64-1:128	2	23	8.7
Pottawatomie	1:32	0	1	0
Seminole	1:64-1:2048	5	11	45.5
Stephens	1:64-1:1024	23	75	30.7
Tulsa	0	0	1	0
Total		171	491	34.8

\*Infection is considered as antibody titers  $\geq$  1:64.  
<sup>†</sup>500 serums were tested; demographic data were missing for 9 serums.

homa Blood Institute volunteers was 34.8%, with the highest percentages of positives being observed at the 1:64 and 1:128 dilutions (total 27.3%) and generally decreasing with increasing dilution thereafter. As expected, the highest percentage in the distribution (37.1%) was for titers of less than 1:16. The table also indicates that selection of the 1:64 titer as indicating seropositivity was, in fact, conservative.

Table 2 shows the distribution of antibody titers among the donors by age. Using the Kruskal-Wallis<sup>12</sup> one-way analysis of variance by ranks, the distribution of antibody titers among the different age groups was not statistically significant ( $H = 6.0$ ;  $p = 0.3$ ). A steady decline in prevalence rates of positive antibody titers was observed ranging from 38.8% for the <20-year age group to 27.6% for the 35- to 44-year age group. The highest prevalence of infection was seen in age group 45 to 55 years, but the rate declined again in the over-54-year age group.

Prevalence of infection was not statistically significant between the 293 men and 198 women involved in the study (Table 3). Within sex groups, the distribution of infection rates by age was not statistically significant for men but was for women ( $\chi^2 = 10.2$ ;  $p = 0.07$ ). Among women, the highest infection rate (47.9%) was recorded for the 20- to 24-year age group, and the lowest infection rate (21.1%) was recorded

for the over-54-year age group. Prevalence of infection among men ranged from 20.4% for the 35- to 44-year age group to 48.3% for the under-20-year age group.

Table 4 indicates the distribution of infection rates by county of residence. Considering only those counties in which at least 10 serum samples were obtained, the prevalence of infection ranged from 8.7% for Oklahoma County to 48.4% for Grady County. Oklahoma County includes the Oklahoma City metropolitan area, with a population of 554,000; Grady County, whose population is 37,000, is a rural area whose major industry is agriculture.<sup>13</sup>

## Discussion

The overall prevalence of legionella infection reported for this group of normal, healthy blood donors was 34.8%, which is much higher than most of the previously reported studies. There was no statistically significant difference in seropositive antibody titer distribution among the different age groups; however, a decrease in prevalence of infection was observed in this study when comparing the 45- to 54-year age group (41.8%) with the over 54-year age group (31.1%). A similar decrease in prevalence of infection in individuals over the age of 54 years has been reported by Edson et al<sup>7</sup>; other researchers<sup>14,15</sup>

have also reported peak prevalence of the 45- to 54-year age groups, but no explanations were given. A person's exposure experience usually increases with age; however, it seems that in this study, as well as in others,<sup>7,8,14</sup> a person's exposure potential apparently becomes less with age as evidenced by the decrease in prevalence rates of infection for individuals 20 through 44 years of age and another decrease after age 54 years.

Another explanation is that the antigenicity of the agent is not as high as that of other microbial agents. Lattimer et al<sup>16</sup> reported considerable variation in serum antibody titers in patients who survived the Legionnaires' disease epidemic of 1976; therefore, seropositive antibody levels may not be long-lasting. As individuals age, lifestyles may have changed so that the exposure potentials become less. For example, the farmer at age 55 years or older may spend less time in the outdoor environment than he did at age 45 years or younger, which would result in less effective contact with soil, soil organisms, and fresh-water streams and ponds; consequently, his antibody titer may fall below the 1:64 level. The fact that there was no statistically significant difference in prevalence rates between men and women would indicate that there is equal exposure. This would seem reasonable, especially in rural areas where, due to similar life-styles, both sexes would likely have the same types of environmental exposures to the agent.

The Oklahoma study sample represented persons from primarily rural communities. Most of the sporadic cases and epidemic outbreaks have occurred in urban areas where serologic surveys have reported low antibody prevalence, from 1.2% to 22.0% for antibody titers of at least 1:128<sup>7,8</sup>; however, a study in rural Iowa reported a 32.0% prevalence for antibody titers of at least 1:64.<sup>17</sup> A rural-urban difference, probably related to soil contact, appears to exist. Individuals living or working in a rural environment would come into greater contact with soil and water than those individuals confined to an urban environment, and since *L pneumophila* has been recovered from soil, animals living in soil, and from fresh-water streams and ponds,<sup>3</sup> the organism and the resulting human contact should be more widespread in agricultural areas like Oklahoma. In this rural environment, where both sexes would likely have the same or similar life-styles, effective contact with the organism may be amplified by irrigation, prevailing winds, and heat-exchange devices.

The relatively high prevalence of asymptomatic or unrecognized infection with *L pneumophila* among a "normal," healthy population of Oklahoma volunteer blood donors indicates rather common, environmental exposures to the agent. Infection with legionella may be endemic in Oklahoma, and perhaps in many other rural states and communities. □

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## Rising Cost of Vaccine

In the past, vaccines necessary to fill public and private sector needs have been available in adequate supply at a reasonable cost. Federal contracts negotiated with certain manufacturers enabled even greater savings to be passed on to state immunization programs. However, a series of lawsuits won by parents whose children had suffered serious complications associated with immunizations (particularly DTP) have, in the past two years, jeopardized the future of immunization programs in the United States.

Some vaccine manufacturers, faced with increased liability insurance rates, stopped producing vaccine. Others have raised their price tremendously in the past two years. As would be expected, the greatest price increase has been for DTP vaccine. Vaccine prices for private providers have gone up at an even more alarming rate. Recently, Lederle Pharmaceuticals Inc. raised the cost of private sector DTP vaccine

from \$4.29 to \$11.40 per dose. The manufacturer claims that \$8.00 (70%) of the \$11.40 is needed to cover increased liability insurance cost.

These price increases, combined with anticipated reductions in federal and state expenditures for vaccine, pose a serious threat to the vaccine delivery system in Oklahoma. Many private physicians have indicated that they will no longer administer vaccine.

It is too early to assess the full impact of these developments. However, vaccine shortages are possible. The greatest concern facing public health officials is that, if the worst predictions are realized, children will remain unimmunized. The result would, of course, be an increase in disease incidence.

Alternatives must be considered to minimize the impact of recent developments in the vaccine market. In Oklahoma, alternate sources of vaccine funding may be explored.

DISEASE	June 1986	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	0	4	8	8
CAMPYLOBACTER INFECTIONS	51	132	142	—
ENCEPHALITIS, INFECTIOUS	1	9	16	14
GIARDIA INFECTIONS	17	84	108	—
GONORRHEA (Use ODH Form 228)	952	6188	5947	7047
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	23	127	125	—
HEPATITIS A	34	167	266	239
HEPATITIS B	14	84	109	123
HEPATITIS, NON-A NON-B	7	28	41	—
HEPATITIS UNSPECIFIED	2	26	45	82
MEASLES (RUBEOLA)	1	12	0	3
MENINGITIS, ASEPTIC	8	29	47	50
MENINGITIS, BACTERIAL				
(non-meningococcal,				
non H. Influenzae)	3	36	43	35
MENINGOCOCCAL INFECTIONS	4	15	21	22
PERTUSSIS	32	56	88	76
RABIES (Animal)	8	37	60	88
ROCKY MOUNTAIN				
SPOTTED FEVER	6	28	59	67
RUBELLA	0	0	1	1
SALMONELLA INFECTIONS	38	184	151	170
SHIGELLA INFECTIONS	9	72	100	125
SYPHILIS (Use ODH Form 228)	12	85	101	100
TETANUS	0	0	1	0
TUBERCULOSIS	20	119	133	152
TULAREMIA	3	5	8	12
TYPHOID FEVER	0	1	1	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	23
BRUCELLOSIS	0
LEGIONNAIRES DISEASE	7
MALARIA	5
REYE SYNDROME	3
TOXIC SHOCK SYNDROME	17
<b>RABIES</b>	
MAYES	Skunk 1
LINCOLN	Skunk 1
WASHITA	Skunk 1

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## Government reorganization & insurance rates/tort claims

### Bickham and Long win slots on state council, select committee

Action in the Oklahoma State Legislature this spring has resulted in prestigious appointments for two OSMA officials.



David Bickham



Larry L. Long, MD

OSMA Executive Director David Bickham has been named to the State Government Reorganization Council by House Speaker Jim Barker. The council has been established to develop guidelines for the creation of a cabinet organization of the executive branch of state government.

Larry L. Long, MD, Oklahoma City, speaker of the OSMA House of Delegates, has been appointed to the Select Committee on Insurance Rates and Tort Claims, which was established by Oklahoma's new tort reform legislation. The committee, composed of ten legislators and eight laymen, is charged with studying, preparing recommendations, and drafting legislation addressing the problem of increasing liability premiums and court awards. Dr Long was appointed by Senate President Pro Tempore Rodger Randle.

### Crosthwait summarizes results of OSMA activity in Chicago

In a July memorandum to the members of the Oklahoma State Medical Association (OSMA), M. Joe Crosthwait, MD, Midwest City, reported on events at the Annual Meeting of the American Medical Association (AMA) the previous month. Dr Crosthwait was chairman of the Oklahoma delegation at the Chicago meeting.

The Oklahoma physicians introduced several resolutions at the meeting, with the following results:

The AMA House of Delegates passed the Oklahoma resolution supporting the position that foreign medical graduates who plan to return to their country of origin have the opportunity to pursue graduate medical education in the United States;

Oklahoma resolutions calling for an end to tobacco supports and warning of the dangers of passive smoking were combined with antitobacco resolutions

from other states in a lengthy substitute resolution which reaffirmed the AMA's support of these positions and its commitment to a smoke-free society by the year 2000;

The Oklahoma resolution noting the role of lean beef as part of a varied and balanced diet was referred to the AMA Board of Trustees for study, and;

The AMA House rejected Oklahoma's resolution to limit the terms of AMA delegates. After the vote, the Oklahoma delegation asked OSMA President Norman L. Dunitz, MD, Tulsa, to study the issue and make recommendations before the end of his term on how to increase access to delegate positions without diminishing the continuity necessary to be an effective force within the AMA.

In reporting other activity, Dr Crosthwait stated that the AMA House of Delegates voted to:

## Chicago activity (continued)

Establish a Young Physicians Section with a voting delegate to address the needs and encourage physicians under 40 years of age to seek leadership positions in organized medicine;

Commend, after lengthy debate in the House of Delegates, the Council on Ethical and Judicial Affairs for its official opinion on withholding or withdrawing life-prolonging medical treatment and urged continued study on this issue;

Maintain AMA dues at current levels;

Grant voting seats in the House of Delegates to the American Academy of Child Psychiatry, American Pediatric Surgical Association, and Renal Physicians' Association;

Grant fully retired physicians under the age of 70 years an 80% dues reduction;

Adopt a comprehensive proposal to replace the current Medicare program with one that would be prefunded, fiscally sound, provide comprehensive protection including catastrophic coverage, offer differing levels of cost sharing based on ability to pay,

ensure free choice among competing health plans, and assure access to high quality care. Perry A. Lambird, MD, Oklahoma City, a member of the AMA Council on Medical Service, was instrumental in preparing this ambitious report which the AMA will distribute widely to appropriate officials in government and the private sector;

Adopt a report calling for discontinuation of alcohol advertising aimed at youth and the addition of health education labels on alcoholic beverage containers;

Endorse federal and state efforts to close commercial sex establishments which threaten public health through the spread of sexually transmitted diseases, and;

Encourage all physicians to continue to treat Medicare patients and to accept assignment based on the economic needs of the patient.

Dr Crosthwait noted that the AMA's Interim Meeting occurs in December and urged OSMA members to convey to him or other Oklahoma delegates their concerns and comments about the future of the medical profession. □

Cited in three decisions since March

## AMA opinion on life support reiterated for the record

On March 15, 1986, the AMA Council on Ethical and Judicial Affairs issued a new opinion on withholding or withdrawing life-prolonging medical treatment.

Since then, reports the AMA's *Hospital Medical Staff Section Newsletter*, three different courts have issued opinions authorizing the removal of feeding tubes, recognizing in each case that the patient could die as a result of such removal. In each case the court cited the AMA council's statement in supporting its decision.

The council's opinion, as adopted, is as follows:

"The social commitment of the physician is to sustain life and relieve suffering. Where the performance of one duty conflicts with the other, the choice of the patient, or his family or legal representative if the patient is incompetent to act in his own behalf, should prevail. In the absence of the patient's choice or an authorized proxy, the physician must act in the best interest of the patient.

"For human reasons, with informed consent, a physician may do what is medically necessary to alleviate severe pain, or cease or omit treatment to permit a terminally ill patient whose death is imminent to die. However, he should not intentionally

cause death. In deciding whether the administration of potentially life-prolonging medical treatment is in the best interest of the patient who is incompetent to act in his own behalf, the physician should determine what the possibility is for extending life under humane and comfortable conditions and what are the prior expressed wishes of the patient and attitudes of the family or those who have responsibility for the custody of the patient.

"Even if death is not imminent but a patient's coma is beyond doubt irreversible and there are adequate safeguards to confirm the accuracy of the diagnosis and with the concurrence of those who have responsibility for the care of the patient, it is not unethical to discontinue all means of life-prolonging medical treatment.

"Life-prolonging medical treatment includes medication and artificially or technologically supplied respiration, nutrition or hydration. In treating a terminally ill or irreversibly comatose patient, the physician should determine whether the benefits of treatment outweigh its burdens. At all times, the dignity of the patient should be maintained." □

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State's "Return to Reason" campaign typical

## Tort reform in 1986 marked by involvement of coalitions

Across the nation, twenty-three states, including Oklahoma, have passed some form of tort reform this year, according to a comprehensive survey by the National Conference of State Legislatures.

The single most significant characteristic of these tort reform efforts, as indicated by the survey, was the willingness of the legislatures to modify tort law for *all* civil actions, not just those involving medical liability.

Furthermore, while reform efforts in the past decade have been promoted primarily by the medical profession, this year's activity was notable for the addition of a broad coalition of businesses, cities, and associations. An April 1986 *American Medical News* survey of pending tort reform legislation showed that forty state medical societies were working with such coalitions on the state level.

In Oklahoma, tort reform came packaged as Senate Bill 488, a controversial compromise formulated by legislative leaders in the waning days of the '86 session. While providing considerably less reform than proponents originally sought, the bill, signed by Governor George Nigh on June 24, represents an important first step in a tort reform effort expected to continue for several years.

Among the more important provisions of the bill are:

Limitation of punitive and exemplary damages to an amount not to exceed actual damages. The court may waive this cap if "clear and convincing" evidence indicates the defendant is guilty of "wanton and reckless disregard for the rights of another, oppression, fraud, or malice";

Recovery of up to \$10,000 in court costs and attorney's fees by the prevailing party if a claim or defense is determined to be frivolous, ie, "asserted in bad faith, not grounded in fact or warranted by law";

Reduction of interest rates on judgments from 15% per year to the US Treasury Bill (T-bill) rate plus 4%. Interest accrues from the date the suit is commenced. Interest on punitive or exemplary damages begins on the date the judgment is entered;

Delineation of awards, if requested by the court,

to ascertain specific amounts awarded for actual damages, future damages, noneconomic damages, etc;

Filing of annual reports by Oklahoma's largest insurance companies, with such reports to contain data regarding the companies' medical and other professional malpractice liability, products liability, and libel insurance operations, including amounts collected in premiums and amounts paid out in claims, and;

Creation of an eighteen-member "Select Committee on Insurance Rates and Tort Claims" to study, prepare recommendations, and draft legislation to address the problem of increasing liability premiums and court awards.

Oklahoma's coalition for tort reform is known as Oklahomans Against Lawsuit Abuse. More than seventy organizations, including the Oklahoma State Medical Association, supported its "Return to Reason" campaign during the 1986 legislative session [JOSMA, July 1986, pp 540-545].

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November JOURNAL**

## Legislative session spawns health and MD-related bills

Although tort reform seemed to grab all the OSMA headlines about doctors and the 1986 Oklahoma legislative session, other health-related legislation also was being passed into law.

**The Department of Human Services (DHS)** was the subject of House Bill 1625, an appropriations bill. HB 1625 specifies that faculty and clinical faculty of the University of Oklahoma College of Medicine and the Oklahoma College of Osteopathic Medicine are considered state employees while engaged in teaching duties and, along with resident physicians and interns while participating in graduate medical education, are protected by the Oklahoma Tort Claims Act that limits liability to a maximum of \$100,000.

The bill also contains several provisions allowing the Oklahoma Teaching Hospitals (OTH) greater flexibility in enhancing their ability to compete for private patients. In addition, a joint House-Senate Interim Committee will study alternate financial operations and governing structures for OTH (Oklahoma Memorial Hospital, Children's Memorial Hospital, and the O'Donoghue Rehabilitation Center), current and projected medical study and other educational programs at the OU Health Sciences Center, and capital needs and alternative uses for existing OTH structures, including modifications for outpatient and HMO needs.

HB 1625 exempts OTH from central purchasing requirements in certain areas subject to approval of the Human Services Commission, allows OTH to enter into joint venture contracts, and retains the Medically Needy Program by allowing the transfer of \$12 million from the Pension Reserve Fund.

Also retained is the Vendor Drug Program, which

provides prescription medications for Medicaid patients by using the state personal needs payment to nursing home clients to match federal dollars in the program.

If state revenues continue to decline, however, both the Medically Needy and Vendor Drug programs face uncertain futures since monies from reserve funds may not be available again next year.

**The Oklahoma Health Planning Commission** was affected by House Bill 1893, which contained significant changes in Certificate of Need requirements, including:

Increase of capital expenditure review for hospitals from \$600,000 to \$3 million effective July 1, 1986; to \$4 million on July 1, 1987; and to \$5 million on July 1, 1988;

Increase of review threshold for nursing homes from \$150,000 to \$500,000 effective July 1, 1986;

Increase of review threshold for acquisition of major medical equipment from \$400,000 to \$3 million;

Review exemption for new hospital services, except those tied to changes in actual bed licensure;

Review exemption for all health care facility acquisitions and hospital debt refinancing projects, and;

Seventy-five percent reduction in the general operating fund appropriation for the Health Planning Commission.

**Physician Reporting of Birth Defects and Cancer** was changed by House Bill 1771. The bill amends current law, which requires physicians to report to the State Health Department all birth defects and occurrences of cancer, and requires that physicians include in these reports the residential and occupational history of each child's parents and of each cancer patient. The identity of those persons shall remain confidential. The law becomes effective on November 1, 1986. □

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Internists planning to attend

## October meeting of Oklahoma's ACP group booked at Shangri-La

Oklahoma specialists in internal medicine and related medical fields will take part in a three-day scientific meeting at Shangri-La Lodge October 23-25, 1986.

The Oklahoma Regional Scientific Meeting of the American College of Physicians (ACP) offers Oklahoma physicians current information on developments in the field of internal medicine. The ACP — a 63,000-member medical specialty society — will hold nearly fifty such sessions throughout the United States, Canada, Mexico, and parts of Central and South America this year.

C. S. Lewis, Jr., MD, Tulsa cardiologist, is president of the ACP this year. William L. Hughes, MD, FACP, clinical professor of medicine at the University of Oklahoma College of Medicine in Oklahoma City, is the ACP Governor for Oklahoma. Dr Hughes coordinates local ACP affairs and represents Oklahoma's college members on the national level. R. Timothy Coussons, MD, FACP, and Kay Bickham, also of Oklahoma City, are working with Dr Hughes as program chairmen.

## Cost of cataract surgery eyed by administration and Congress

The *AMA Newsletter* reports that both the administration and Congress are exploring ways to cut Medicare payments for cataract surgery. Some members on both the Ways and Means and the Commerce subcommittees are interested in proposals that would result in major cuts in payments. The Ways and Means panel is looking at a provision that would permit Medicare cataract payments only to physicians who agree to hold charges below some specific amount, such as \$1,100.

The administration also is poised to cut payments for cataract surgery. A final regulation setting guidelines for reducing payments that are not regarded as "inherently reasonable" will be published. National limits on cataract payments will be issued soon thereafter.

Health Care Financing Administration (HCFA) officials say the cuts are justified because cataract surgery with an intraocular lens implant takes slightly less time but is reimbursed more generously (\$1,580) than when the surgery is done without an implant (\$1,000). □

Prominent college members, notably officers and members of the board of regents, act as official representatives to regional meetings, speaking about national college activities as well as their areas of medical expertise. At this year's Oklahoma gathering, ACP Secretary General George T. Lukemeyer, MD, FACP, executive associate dean, medical director, and professor of medicine at the Indiana University School of Medicine in Indianapolis, will fill this leadership role.

An added feature at many ACP scientific meetings is the participation of staff members from the college's Department of Public Policy, which provides the membership with a vital link to legislative activities that affect health care and influence subsequent ACP policy decisions.

For details on the October meeting, contact William L. Hughes, MD, FACP, Memorial Professional Building, Suite 200, 13439 North Broadway Extension, Oklahoma City, OK 73114, (405) 752-8780. □

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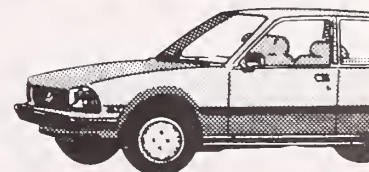
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More light shed on hot topic

## Media spotlighting of crack generally dim on medical data

A great deal of media attention recently has focused on "Crack." Some of these sources seem to imply that this is a new drug with unique toxicity. In fact, crack is an old drug (cocaine) which has been processed to its free-base form. Crack shares the same toxicity as cocaine. What then, sets it apart?

Cocaine in its traditional forms (cocaine hydrochloride, cocaine sulfate, or cocaine base) is usually inhaled as a powder through the nose or dissolved and injected intravenously. Smoking of these forms destroys the cocaine by pyrolysis. Crack, on the other hand, is always smoked. Flakes of crack are placed in a pipe or sprinkled on a tobacco or marijuana cigarette. While the inherent vasoconstrictive properties of snorted cocaine tend to diminish absorption through the nasal vasculature as greater amounts are inhaled, this self-limiting property is lost when the product is smoked as the free-base. It is for this reason that the danger of overdose and severe toxicity with crack is greater. Crack smokers face the additional danger of developing pulmonary gas exchange abnormalities which have been detected in long-term chronic users.

The popularity of crack among drug users may relate to the fact that it is very inexpensive, readily available, and easy to use. A small vial containing three flakes of crack and equivalent to 100-300 mg of cocaine can be purchased on the street for \$10-\$20. The drug also supplies instant gratification in the sense that physiological effects are intense and appear within seconds to minutes following use. These effects persist for only 10 to 30 minutes. Media attention advertises availability and contributes to an image of crack as "the new thing to do." As with cocaine, dependency relates more to psychosocial factors than to addiction in a strict physiological sense.

Statistics regarding prevalence of use are not readily available. At Bellevue Hospital, for example, in the month of March 1986, there were 244 drug-related visits to the emergency room. Most of these involved multiple drugs and many involved unspecified substances. Cocaine was specifically noted in 81 cases, of which 19 were admitted, and crack was noted in 8 cases, of which 5 were admitted for hospitalization. The New York City Poison Control Center is consulted on 5-10 hospitalized cases of crack

abuse each week. Phoenix House, a drug rehabilitation center, handles approximately 100 admissions per week of which 70 percent use cocaine. Among this group of cocaine users, 90 percent use crack.

Crack, or cocaine free-base, is for the most part manufactured locally. The relatively simple manufacturing process allows for the existence of many small and unsophisticated backroom factories. The name "crack" may indeed relate to the production process: a solid chunk of free-base must be cracked up into flakes. Alternatively, it has been suggested that the name refers to the cracking sound during heating or to the fact that flakes resemble bits of plaster that fall from cracks in walls.

Crack, or free-base cocaine, is a sympathomimetic agent. Toxic effects are referable mainly to the central nervous system and cardiovascular system with a biphasic pattern of intense excitation followed by depression. Neurologic effects may include euphoria, anxiety, tremulousness, seizures, and CNS depression. There is no evidence that crack specifically causes violent behavior. Cardiovascular effects include elevation of blood pressure, sinus tachycardia, and in severe cases, life-threatening dysrhythmias and hypotension. Other effects include elevation of temperature, mydriasis, and tachypnea or respiratory depression. Recent reports of cerebrovascular hemorrhage and myocardial ischemia or infarction are cause for great concern, but require additional investigation. Chronic abuse may lead to perceptual disturbances, behavioral changes, self-neglect, and pulmonary gas exchange abnormalities.

Treatment of acute toxicity should include principles of general poison management. Toxic effects are usually short-lived. Supportive treatment is generally all that is required while keeping in mind the possibility of serious complications listed above. Seizures and dysrhythmias are treated with standard protocols. Concomitant ingestion of other drugs is common and often complicates the clinical picture.

*The preceding article was reprinted with permission from City Health Information, a publication of the New York City Department of Health, Vol 5, No 10, July 2-9, 1986. The article originally appeared under the title "Crack: Cocaine Repackaged."*

## DEATHS

### IN MEMORIAM

#### 1985

<i>Floyd L. Waters, MD</i>	<i>March 5</i>
<i>Forest R. Brown, MD</i>	<i>March 19</i>
<i>William M. Leebron, MD</i>	<i>March 22</i>
<i>Louis A. Martin, MD</i>	<i>March 22</i>
<i>Don D. Sullivan, MD</i>	<i>March 27</i>
<i>Hanna B. Karam, MD</i>	<i>March 28</i>
<i>John R. Cotteral, MD</i>	<i>April 30</i>
<i>Ernest S. Kerekes, MD</i>	<i>June 8</i>
<i>L. Chester McHenry, MD</i>	<i>June 8</i>
<i>Seigul J. Polk, MD</i>	<i>June 10</i>
<i>Murray M. Cash, MD</i>	<i>June 11</i>
<i>Franklin Jesse Nelson, MD</i>	<i>June 13</i>
<i>Robert L. Kendall, MD</i>	<i>June 21</i>
<i>Marion K. Ledbetter, MD</i>	<i>July 3</i>
<i>James Floyd Moorman, MD</i>	<i>August 8</i>
<i>Oscar R. White, MD</i>	<i>August 14</i>
<i>Maurice P. Capehart, MD</i>	<i>August 29</i>
<i>Meredith M. Appleton, MD</i>	<i>September 7</i>
<i>Robert A. Northrup, MD</i>	<i>September 8</i>
<i>Carl H. Bailey, MD</i>	<i>September 9</i>
<i>Hugh B. Spencer, MD</i>	<i>September 13</i>
<i>Bernice E. McCain, MD</i>	<i>September 14</i>
<i>Robert E. Campbell, MD</i>	<i>September 23</i>
<i>Minard F. Jacobs, MD</i>	<i>September 30</i>
<i>Robert Ray Rupp, MD</i>	<i>October 2</i>
<i>William C. Moore, MD</i>	<i>October 24</i>
<i>Michael Wayne Durbin, MD</i>	<i>November 13</i>
<i>Alan Luis Gorena, Jr., MD</i>	<i>November 19</i>
<i>William Hampton Garnier, MD</i>	<i>November 20</i>
<i>Jesse Ray Waltrip, MD</i>	<i>November 30</i>
<i>Charles F. Obermann, MD</i>	<i>December 30</i>

#### 1986

<i>Alexander Poston, MD</i>	<i>January 3</i>
<i>Francis M. Duffy, MD</i>	<i>February 5</i>
<i>Edward L. Leonard, MD</i>	<i>February 14</i>
<i>William C. Tisdal, MD</i>	<i>February 24</i>
<i>Fred D. Switzer, MD</i>	<i>May 10</i>
<i>Phillip Wade Jones, MD</i>	<i>May 18</i>
<i>Herbert L. Owen, MD</i>	<i>May 28</i>
<i>Marianne Elsbeth Kosbab, MD</i>	<i>June 13</i>
<i>William W. Rucks, Jr., MD</i>	<i>June 27</i>
<i>Ralph A. Smith, MD</i>	<i>July 27</i>
<i>Howard D. Tuttle, MD</i>	<i>August 3</i>

### Herbert Leo Owen, MD

1917 - 1986

OSMA Life Member Herbert L. Owen, MD, of Bartlesville died May 28, 1986. Dr Owen, a pediatrician, earned his medical degree from the University of Oklahoma School of Medicine in 1950. He practice in Seminole, Okla, and Denison, Tex, before settling in Bartlesville. A native of Grandfield, Okla, Dr Owen was on active duty with the US Army for two years during World War II.

### Ralph Argyle Smith, MD

1909 - 1986

Retired Oklahoma City general practitioner Ralph A. Smith, MD, died July 27, 1986. Born in Edina, Mo, Dr Smith was graduated from St Louis University School of Medicine in 1935. He was in private practice in Oklahoma City for 47 years and was a professor at the University of Oklahoma School of Medicine from 1936 through 1975. Dr Smith was a past president of the Oklahoma County Medical Society and of the Oklahoma City Clinical Society.

### William Charles Tisdal, MD

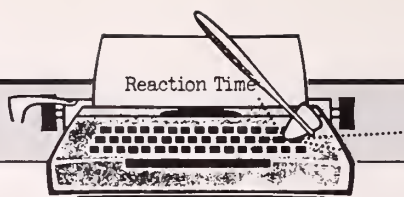
1901 - 1986

William C. Tisdal, MD, retired Clinton general practitioner, died February 24, 1986, in Youngstown, Ariz. Dr Tisdal established his practice in Clinton in 1938, after first making his home in Elk City. He received his medical degree from the University of Oklahoma in 1934 and was commissioned in the US Army Medical Corps in 1942. He was discharged in 1944 with the rank of captain.

### Howard D. Tuttle, MD

1923 - 1986

Wagoner general practitioner Howard D. Tuttle, MD, died August 3, 1986, in a Tulsa hospital. A 1951 graduate of the University of Oklahoma School of Medicine, Dr Tuttle established his practice in Wagoner the same year and joined the staff of the Muskogee Regional Medical Center in 1953. Dr Tuttle served on active duty with the US Army Medical Corps for 27 months during World War II.



## OKC physician takes exception to July story on breast cancer

*To the editor:* Breast cancer seems to be fashionable, as imaging centers promote “free” examinations and the “latest” techniques [JOSMA, July 86, p 481]. But who is interested in protecting patients from gimmicks or promoting quality care.

The “latest” techniques — lite scanning, thermog-

annual meeting in the JOURNAL because of the expense. I fought that move quite vigorously as I felt the general membership needed to be exposed to the activities of the association at the meeting. Your July edition of the JOURNAL convinces me that I was right. (Those of us there also thoroughly enjoy the memories.)

Best wishes.

Floyd F. Miller, MD  
Tulsa

### Related article, p 683

raphy, and ultrasound — have all undergone innumerable studies and have failed to show any clinical value in breast screening as indicated by policy statements of the American College of Radiology and the National Council of Radiation Protection.

In too many instances, these “impostors” detract from the proven methods of self-examination, physical examination, mammography and, most critical, the direct mammographic-physical examination correlation.

The medically sound exam then becomes a slick sweatshop with substandard mammographic quality control and without a physician’s direct mammographic-physical correlation.

This approach is not in the patient’s medical or financial best interests and should not be promoted by quality physicians or by AMA-sponsored publications.

Breast screening is a valuable, reassuring tool that should be used, but not abused.

Mark E. Idstrom, MD  
Oklahoma City

## JOURNAL gets pat on back from Past President Miller

*To the managing editor:* Just a note to say that the July annual meeting edition of the JOURNAL is superb. We appreciate your excellent work.

You may not know that about 7 years ago there was a move to not publish the proceedings of the

*Letters for Reaction Time should be sent to the editor, OSMA JOURNAL, 601 Northwest Expressway, Oklahoma City, OK 73118.*

## BOOK SHOP

**Research and Discovery in Medicine: Contribution from Johns Hopkins.** By A. McGehee Harvey. Baltimore: Johns Hopkins University Press, 1981, pp 322, illustrated, \$25.00.

The Johns Hopkins Hospital opened in 1889. Four years later, the Johns Hopkins School of Medicine matriculated its first students. These events marked a significant change in medical education, with particular emphasis on the relation between the basic scientist and the practicing physician — clinical science. In another one of his contributions to medical history, A. McGehee Harvey, professor of medicine emeritus at Johns Hopkins, traces the history of clinical research at that institution.

The book is made up of 21 essays dealing with various aspects of medical history that have involved the Johns Hopkins Medical Center. Most but not all of the papers have been published in the *Johns Hopkins Medical Journal*. There is wide variation in the topics of the various chapters. Some focus on a major figure at Johns Hopkins such as William Osler, Henry Hurd, William S. Halsted, or G. Canby Robinson. Others are topical in orientation and treat a specific disease or subject which involves several persons who had some connection with Hopkins. These subjects include yellow fever, tuberculosis, the role of snake venom in medical research, and scarlet fever.

In addition to these topics, there are others which in effect make the book an interesting sample of biomedical history. For example, there are chapters dealing with the development of various departments. There is an interesting chapter about William S. Halsted and his influence in surgical training, particularly the development of the pyramidal surgical training program. Here are discussed some of the most important surgeons connected with the Halsted school, including Joseph Bloodgood, George Heuer, Monty Reid, Brooks, Barney, and others. There is also considerable information about the problems incurred in developing and opening the Johns Hopkins Hospital. In addition to Hopkins, the book also considers academic medicine at the Rockefeller Hospital, Vanderbilt, and Columbia University, to mention only a few institutions.

One of the more attractive features of this book are the biographical essays on persons who made important contributions but are not as well known as Osler, Halsted, and Cushing. These include Charles E. Simon, an early virologist; Warfield M. Firor, a multifaceted surgeon; anatomist Lewis Weed; and psychologist W. Horsley Gantt.

Another strong feature of the book are the interesting illustrations which provide an important historical album of contributors to medical education and research. The author is lucid and interesting. It is an informative account.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Immunology in Medicine. A Comprehensive Guide to Clinical Immunology.** 2nd Edition. Edited by E. J. Holborow and W. G. Reeves. London and New York: Grune and Stratton, 1983, pp 655, illustrated, price not given.

It is now recognized not only that the immune system protects against microbial invasion but that aberrations of it can lead to disease. This is a general textbook of immunology that is designed for the clinician, irrespective of specialty. It assumes that the physician may have only a skeleton knowledge of immunology and wants to learn more about the advances of clinical and laboratory research in immunology which have made major contributions to the diagnosis and management of disease.

This, the second edition, has been partially rewritten but it continues to communicate the practical importance of advances in immunology. All of the contributors are from Great Britain. The book is di-

vided into five major sections: a general introduction and seven subsequent chapters cover fundamental aspects of the immune system; another five review the role of the immune system in disease; 13 chapters are devoted to immunologic disorders of major body organs or systems; three concentrate on lymphoproliferative and malignant disease; and three concluding chapters focus on transplantation and therapeutic aspects of immunology. Many of the chapters have been written by immunologists who have made significant contributions to their specialty and present in a readable way their personal views.

This book provides a good overview of the discipline of immunology in Britain at the present time. It is a useful contribution.

*Harris D. Riley, Jr., MD  
Oklahoma City*

### **Acid Base Balance: A Manual for Clinicians.**

By Jorge A. Quintero, MD. St. Louis: Warren H. Green, Inc., 1979, pp 128, \$10.50.

In this short manual for clinicians, the author presents an approach to the evaluation of acid-base disturbances that can aid in the diagnosis of simple and complex acid-base disorders. Acid-base chemistry and its most basic equations are reviewed, and the derivations of the most commonly used acid-base diagrams are explained. The major mechanisms of respiratory and renal regulation of acid-base homeostasis are briefly discussed, and predictive data, which include 95% confidence limits of compensation for pure respiratory and metabolic disorders, are compiled from a number of reference studies. Conditions causing and diagnostic clues to various acid-base disturbances are touched on as are a limited number of treatment modalities.

In the largest chapter in the book, the author presents equations for calculating the percentage of compensation (compensation achieved vs complete compensation) for respiratory and metabolic acid-base disorders and applies the equations and predictive data to a large number of examples. The book concludes with a sequential summary of the material presented and a short discussion of methods for evaluating pulmonary and system factors affecting respiratory drive and oxygen delivery to the tissues.

The book provides methods for specifically assessing acid-base status and the degree of respiratory and metabolic compensation. Because of its physicochemical orientation, only the clinician who already has some familiarity with the equations used

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## Book Shop (continued)

(ie, dissociation equilibria and the Henderson-Hasselbalch equation) will want to consider reading it. The book also has an older copyright, and the format and quality of the text (ie, typographical errors) leave something to be desired. Finally, it has a limited number of references (only 32). Despite these shortcomings, the author presents an interesting and unusual approach to the evaluation of acid-base disorders for the clinician who is interested in exploring this topic in greater depth.

*David L. Donaldson, MD  
Oklahoma City*

### **Citizen Soldiers. Oklahoma's National Guard.**

By Kenny A. Franks. Norman: University of Oklahoma Press, 1984, illustrated, pp 234.

With this book the author, Kenny A. Franks, has made an important contribution to Oklahoma's military history.

As pointed out in the preface, the concept of a standing militia — citizen-soldiers — took root in the early history of the nation. Citizen-soldiers have played a major role in every American conflict since the time of the first colonists. The concept of the standing militia is incorporated into the United States Constitution.

The history of citizen-soldiers in Oklahoma began before the territorial days. Various Indian tribes fashioned various types of tribal military groups. With the organization of Oklahoma Territory in 1890, the legislature formed a territorial militia which, in 1895, evolved into the Oklahoma Territory National Guard. During the Spanish-American War, two units of citizen-soldiers were raised from Oklahoma and Indian territories for service. With statehood, the National Guard expanded throughout Oklahoma. First mustered into federal service for duty on the Mexican border in 1916, the Oklahoma National Guard

merged with the Texas National Guard, forming the 36th National Guard Division, and served in Europe in World War I. Another group of citizen-soldiers from Oklahoma and Texas was organized into the 90th, or Texas-Oklahoma, Division; it served in France.

During the early 1920s, Oklahoma's most illustrious citizen-soldier unit — the 45th Infantry Division — was organized. The Thunderbird Division, as it was also known, had components in Oklahoma, Colorado, New Mexico, and Arizona, but after World War II, it became an all-Oklahoma unit. It served both the state and the nation for more than 45 years before being reduced to brigade status in 1968. In addition, the post-World War II period saw the 125th and the 185th squadrons of the US Air National Guard become a part of Oklahoma's citizen-soldier tradition.

At the onset of the Vietnam War, the famous Thunderbird Division boasted more combat days than any other American military unit. It participated in heavy combat in Sicily, Salerno, Anzio, and Southern Europe in World War II and in some of the major battles in Korea. The author stresses that guardsmen, despite their key role in national defense, are integral members of their communities.

Franks has made extensive use of the documents, photographs, maps, and private collections housed in the 45th Infantry Division Museum in Oklahoma City. A member of the 45th himself, Franks interviewed many members of the 45th, both active and retired. The text is well supplemented by many excellent photographs, several of Bill Mauldin's cartoon sketches of the 45th in action, and a series of useful maps depicting the major campaigns in which the 45th was involved.

In addition to extensive chapter notes, there are other useful sections including a table of organization and a pertinent bibliography. The oversized book is well-printed, and the illustrations are clear. It is a valuable addition to Oklahoma history.

*Harris D. Riley, Jr., MD  
Oklahoma City*

## How's that again?

Seen in a prominent medical journal several years ago: "Subsequent to submission for publication, an additional seven patients have been treated."

## MISCELLANEOUS ADVERTISEMENTS

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The 1986 PLICO professional liability insurance policy you received contains a special endorsement or requirement making attendance at an OSMA/PLICO-sponsored Loss Prevention Seminar **mandatory** at least once in every three years. If a physician has never attended a seminar, he or she must attend one during 1986. If a physician has not attended a program since 1983, they must attend this year, also. Any physician needing to attend in 1986, and failing to do so, will not be eligible for renewal of their insurance for calendar year 1987.

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#### **1986 Seminar Schedule\***

<b>Sept. 10</b> , Wed., 6-9 p.m.	<b>Lawton</b> Montego Bay Hotel, 1125 E. Gore
<b>Sept. 17</b> , Wed., 6-9 p.m.	<b>Muskogee</b> Holiday Inn, 800 South 32nd
<b>Sept. 24</b> , Wed., 6-9 p.m.	<b>McAlester</b> Holiday Inn, US Hwy 69 Byp South
<b>Oct. 8</b> , Wed., 6-9 p.m.	<b>Enid</b> Ramada Inn, 3005 W. Garriott Road
<b>Oct. 22</b> , Wed., 6-9 p.m.	<b>Oklahoma City</b> Conference Center, 5901 N. May (58th & May)
<b>Oct. 23</b> , Thur., 6-9 p.m.	<b>Tulsa</b> Sheraton Inn Skyline East, 6333 E. Skelly

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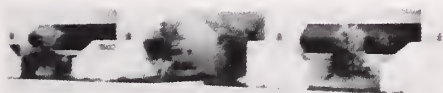


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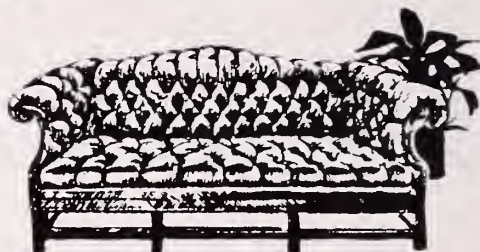
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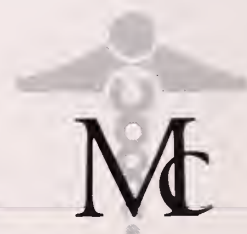
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### Contributions

Articles submitted for publication, including Annual Meeting papers, become the sole property of the JOURNAL and must not have been published elsewhere. The Editorial Board reserves the right to edit any material submitted. Manuscripts must be typewritten, double-spaced, and submitted in duplicate. Receipt of manuscripts will be acknowledged, and unpublished manuscripts will be returned. The JOURNAL does not assume responsibility for the statements or opinions of any contributor.

### Style

All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

### Illustrations

Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

### News

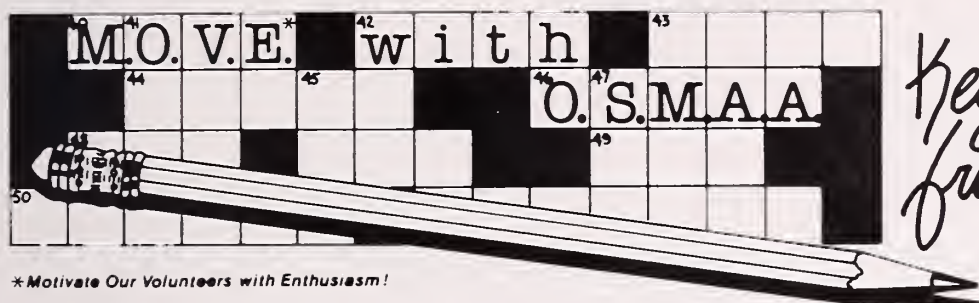
Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc., are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

### Reprints

Authors will receive reprint order forms from the Transcript Press, 222 East Eufaula, Norman, Oklahoma 73069, prior to publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

### Back Issues

Microfilm copies of back issues of the JOURNAL can be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.



*Key Words  
from Kelsey*

**T**he OSMA Auxiliary is ready to meet the challenges of a new year. We will continue to work hand in hand with you in improving the public image of the physician, in sponsoring health education projects, and in promoting positive legislative endeavors.

The OSMAA is a unique organization of physician spouses, with 1,367 members from Oklahoma's 15 auxiliaries. We are joined together by a common interest in the future of medicine and the quality of health care in our communities.

We *must* protect the physician-patient relationship which has made health care what it is today in this country. We must educate ourselves, our friends, and our legislators about the necessity of tort reform and the dangers of government intervention in the "fee-for-service principle."

The OSMA Auxiliary has created a new computer program which provides a statewide directory of our membership. This is cross-indexed by county and gives information on each member's house, senate, and congressional district. Our Legislative Action Committee has a plan to respond more quickly and effectively when legislation arises that affects medicine. In addition to forming a phone bank and assisting the OSMA with its speaker's bureau, the state auxiliary will continue to network with county legislation chairmen and plan various workshops on the legislative process, as well as our annual State Day at the Capitol.

In the area of health projects, we will continue with the popular Medi-File Project. Medi-File cards are available free of charge to physicians who are OSMA members. These wallet-size prescription cards help elderly patients keep track of their medications and are perceived as a service provided by their own physicians.

Our recent Fall Confluence, held September 15 and 16 at the Park Suite Hotel in Oklahoma City, provided auxiliary members with leadership training and workshops dealing with publicity and media skills, fund-raising, and ideas for community health projects. Three speakers gave talks on women's health issues. Topics included "Teenage Pregnancy," "Anorexia and Bulimia," and "Hormonal Changes in a Woman's Lifetime." We also showed the OSMA film, *Preserving Tradition, Embracing Change*.

A high priority for the OSMA Auxiliary is fund-raising for Oklahoma medical schools. Last year, our AMA-ERF project (American Medical Association Education and Research Foundation) raised \$32,927.81 for medical schools in our state. The money is used by medical school deans toward the pursuit of excellence in the schools' programs, as well as financial assistance to students.

By providing you with an overview of auxiliary projects and activities, I hope that you will encourage *your* spouse to join your local auxiliary or to become a member-at-large if there is no auxiliary in your area. We too, are a federation of county, state, and national membership, and numbers count. Simply call Beth Dumler at the OSMA office for the number of the auxiliary membership chairman in your community. And remember, when it's time to join OMPAC-AMPAC, your spouse needs to belong separately to show political clout and involvement. Numbers count here, too.

"Motivate our Volunteers with Enthusiasm — M.O.V.E. with O.S.M.A.A." This is my theme for the year. Help us help you through your support of the auxiliary this year.

Kelsey P. Walters  
OSMAA President

## THE LAST WORD

■ **The University of Oklahoma Health Sciences Center (OUHSC) Library** began the second year of a National Library of Medicine grant on September 1. The grant allows the library to teach non-urban health professionals to search MEDLINE, the computerized data base from which *Index Medicus* is printed. MEDLINE can be searched by micro-computer from home, office, or hospital and will give the physician access to references for medical journal articles. The seminars have been designated for three CME credit hours in Category 1 of the Physician's Recognition Award of the AMA and also are acceptable for three prescribed hours by the American Academy of Family Physicians. The library is seeking a minimum of ten non-urban hospitals or clinics with groups of health professionals interested in being a part of or sponsoring this training. For information contact Ruth Wender, project coordinator, or Mary Huffman, project librarian, at 1-800-522-0222, extension 2349, or in Oklahoma City call 271-2349.

■ **The Oklahoma Medical Political Action Committee (OMPAC)**, aided by election-year activities in the state, has reached an all-time high in membership. At press time, OMPAC's membership roll totaled 1,380, well above the total of 793 for all of last year. The membership drive continues, however, and physicians are being encouraged to support this strong political voice for themselves and their patients.

■ **Now available free of charge: "The AMA: Fighting for the Future of Medicine,"** a membership recruitment brochure, from the AMA Division of Membership, (312) 645-5314. Also, from the National Institute on Aging, a 75-page paperback entitled *Age Words: A Glossary on Health and Aging*, designed for a general audience including the elderly and their families. Write to the NIA Information Center/AW, 2209 Distribution Circle, Silver Spring, MD, 20910, or call (301) 495-3455.

■ **Women with clinically suspicious breast lumps** should undergo biopsies even if mammography results are negative, according to a study reported in the July *Archives of Surgery*. Jeremiah O. Young, MD, of Framingham Union Hospital, Framingham, Mass, and Boston University, and colleagues studied the effectiveness of mammography in diagnosing

cancer in 342 women. "The number of women with cancer of the breast and false-negative mammogram reports ranged from 11% to 25%, depending on how equivocal mammogram reports were interpreted," the researchers say. Mammography correctly diagnosed malignancy in 89% of cases and benign conditions in 70% of cases. The mean predictive value of a positive mammogram in women 50 years of age and older was considerably higher than in women younger than 50, the report adds.

■ **The AMA is once again urging physicians** to relay their experiences with peer review organizations (PROs) to its headquarters in Chicago. The PRO Monitoring Project is part of an ongoing AMA activity to keep abreast of developments in the implementation of the federal government's PRO program. Physicians wishing to participate should describe their experience(s) in a brief letter directed to the AMA PRO Monitoring Project, Department of Health Care Review, AMA, PO Box 10947, Chicago, IL 60610. All sources of information will be kept confidential.

■ **United Cerebral Palsy of Oklahoma, Inc.**, has announced the availability of a recently published booklet "Diagnosis: Cerebral Palsy, Where Do We Go from Here?" Single copies are free of charge to families and individuals involved with cerebral palsy or related disorders. Professional copies are \$2.00 each. Contact United Cerebral Palsy of Oklahoma, Inc, 2701 North Portland, Oklahoma City, OK 73107.

■ **Physicians are reminded that effective October 1, 1986**, state Medicaid agencies will be required to use and accept exclusively the AMA-developed standard health insurance claim form designated Standard Form HCFA 1500. A product of AMA efforts, the form is already required by Medicare and has been adopted for use by the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), the US Department of Labor, and many private insurance companies. The AMA has several versions of the form available, including those for computer printers. Bulk orders are discounted and members receive a 10% discount. For information contact AMA Insurance Form, Book and Pamphlet Fulfillment, c/o AMA, PO Box 10946, Chicago, IL 60610. □

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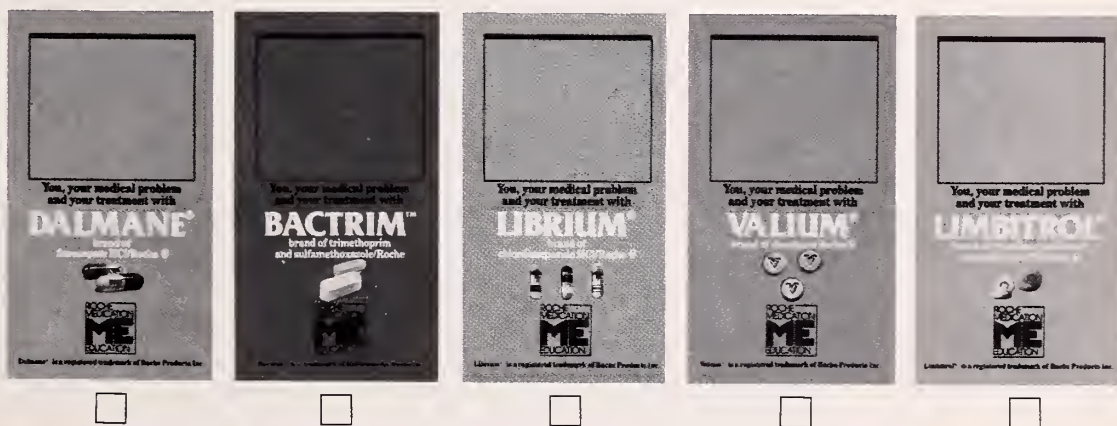
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OKLAHOMA STATE MEDICAL ASSOCIATION  
OCTOBER 1986



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# JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

OCTOBER 1986

VOL. 79, No. 10

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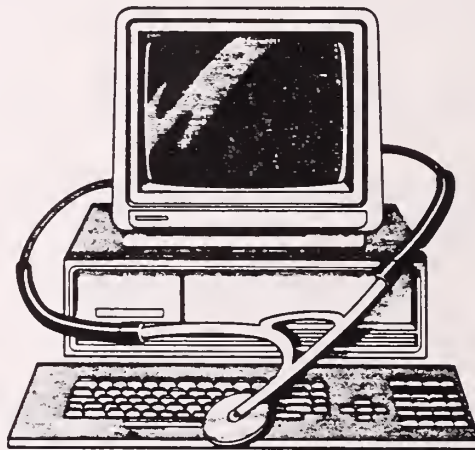
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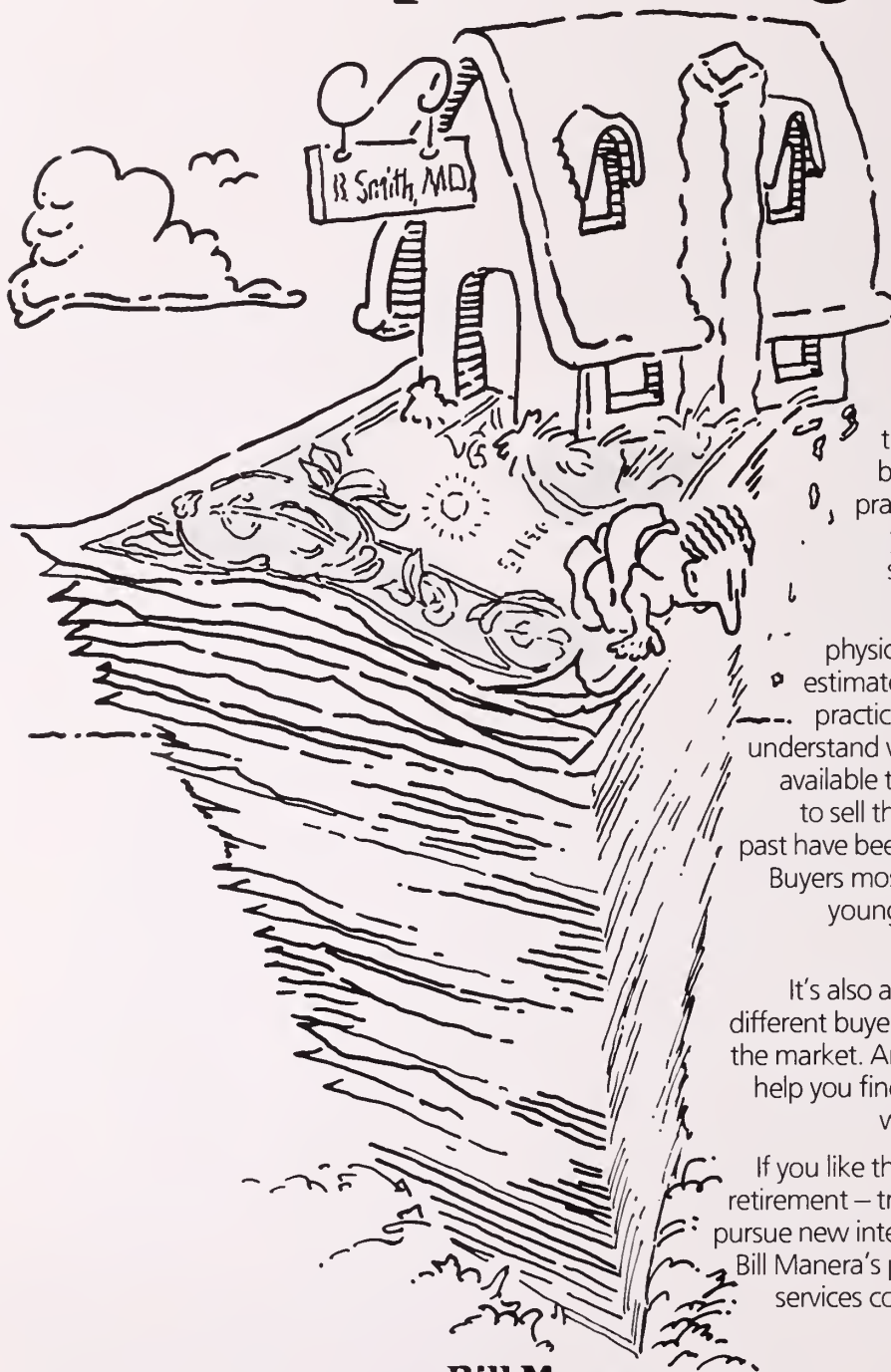
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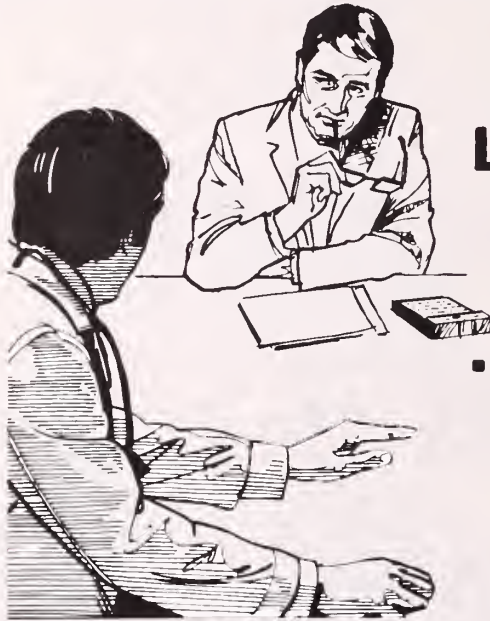
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ZANTAC® 150 h.s.

ranitidine HCl/Glaxo 150 mg tablets

EFFECTIVE MAINTENANCE THERAPY

for healed duodenal ulcer patients

# CONFIRMED

In two randomized, double-blind, and well-controlled clinical trials, ZANTAC 150 mg h.s. significantly superior to cimetidine 400 mg h.s. for maintenance therapy in healed duodenal ulcers.

Percent of patients with observed duodenal ulcer recurrence

		0-4 months	0-8 months	0-12 months	No. patients
USA <sup>1</sup>	ranitidine 150 mg h.s.	9%	14%*	16%†	60
	cimetidine 400 mg h.s.	23%	34%	43%	66
UK, Ireland, Australia <sup>2</sup>	ranitidine 150 mg h.s.	8%‡	14%‡	23%‡	243
	cimetidine 400 mg h.s.	21%	34%	37%	241

\*p=0.02

†p=0.01

‡p<0.004

%=life-table estimates

All patients were permitted prn antacids for relief of pain.

These two trials used the currently recommended dosing regimen of cimetidine (400 mg h.s.) and ranitidine (150 mg h.s.). A comparison of other dosing regimens has not been studied.

The studied dosing regimens are not equivalent with respect to the degree and duration of acid suppression or suppression of nocturnal acid.

The superiority of ranitidine over cimetidine in these trials indicates that the dosing regimen currently recommended for cimetidine is less likely to be as successful in maintenance therapy.

Convenient once-a-night dose with a  
low incidence of side effects<sup>3</sup>

Headache, sometimes severe, seems to be related to ranitidine administration. Other side effects have been reported; for a complete listing, see the ADVERSE REACTIONS section in the Brief Summary.

No significant interference with the hepatic cytochrome  
P-450 enzyme system at recommended doses

ZANTAC 150 mg has no significant drug interactions with theophylline, phenytoin, or warfarin. The bioavailability of certain medications whose absorption is dependent on a low gastric pH may be altered when ZANTAC or other medications that decrease gastric acidity are administered.

***Zantac<sup>®</sup> 150***  
*ranitidine HCl/Glaxo 150 mg tablets*

One tablet at bedtime  
for maintenance

See next page for references and  
Brief Summary of Product Information.

**Glaxo** / 

# CONFIRMED

## Zantac 150

ranitidine HCl/Glaxo 150 mg tablets

*One tablet at bedtime for maintenance therapy  
in healed duodenal ulcer patients*

#### References:

1. Silvis SE, Griffin J, Hardin R, et al: Final report on the United States multicenter trial comparing ranitidine to cimetidine as maintenance therapy following healing of duodenal ulcer. *J Clin Gastroenterol* 1985;7(6):482-487.
2. Gough KR, Korman MG, Bardhan KD, et al: Ranitidine and cimetidine in prevention of duodenal ulcer relapse: A double-blind, randomised, multicentre, comparative trial. *Lancet* 1984;ii:659-662.
3. Data available on request, Glaxo Inc.

**ZANTAC® 150 Tablets**  
(ranitidine hydrochloride)  
**ZANTAC® 300 Tablets**  
(ranitidine hydrochloride)

#### BRIEF SUMMARY OF PRODUCT INFORMATION

See complete product information before prescribing. The following is a brief summary.

#### INDICATIONS AND USAGE: ZANTAC® is indicated in:

1. Short-term treatment of **active duodenal ulcer**. Most patients heal within four weeks.
2. **Maintenance therapy** for duodenal ulcer patients at reduced dosage after healing of acute ulcers.
3. The treatment of **pathological hypersecretory conditions** (eg, Zollinger-Ellison syndrome and systemic mastocytosis).
4. Short-term treatment of **active, benign gastric ulcer**. Most patients heal within six weeks and the usefulness of further treatment has not been demonstrated.
5. Treatment of **gastroesophageal reflux disease (GERD)**. Symptomatic relief commonly occurs within one or two weeks after starting therapy. Therapy for longer than six weeks has not been studied.

In active duodenal ulcer, active, benign gastric ulcer; hypersecretory states; and GERD, concomitant antacids should be given as needed for relief of pain.

**CONTRAINDICATIONS:** ZANTAC® is contraindicated for patients known to have hypersensitivity to the drug.

**PRECAUTIONS: General:** 1. Symptomatic response to ZANTAC® therapy does not preclude the presence of gastric malignancy. 2. Since ZANTAC is excreted primarily by the kidney, dosage should be adjusted in patients with impaired renal function. Caution should be observed in patients with hepatic dysfunction since ZANTAC is metabolized in the liver.

**Laboratory Tests:** False-positive tests for urine protein with Multistix® may occur during ZANTAC therapy, and therefore testing with sulfosalicylic acid is recommended.

**Drug Interactions:** Although ZANTAC has been reported to bind weakly to cytochrome P-450 in vitro, recommended doses of the drug do not inhibit the action of the cytochrome P-450-linked oxygenase enzymes in the liver. However, there have been isolated reports of drug interactions which suggest that ZANTAC may affect the bioavailability of certain drugs by some mechanism as yet unidentified (eg, a pH-dependent effect on absorption or a change in volume of distribution).

**Carcinogenesis, Mutagenesis, Impairment of Fertility:** There was no indication of tumorigenic or carcinogenic effects in lifespan studies in mice and rats at doses up to 2,000 mg/kg/day.

Ranitidine was not mutagenic in standard bacterial tests (*Salmonella*, *E coli*) for mutagenicity at concentrations up to the maximum recommended for these assays.

In a dominant lethal assay, a single oral dose of 1,000 mg/kg to male rats was without effect on the outcome of two matings per week for the next nine weeks.

**Pregnancy: Teratogenic Effects: Pregnancy Category B:** Reproduction studies have been performed in rats and rabbits at doses up to 160 times the human dose and have revealed no evidence of impaired fertility or harm to the fetus due to ZANTAC. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

**Nursing Mothers:** ZANTAC is secreted in human milk. Caution should be exercised when ZANTAC is administered to a nursing mother.

**Pediatric Use:** Safety and effectiveness in children have not been established.

**Use in Elderly Patients:** Ulcer healing rates in elderly patients (65 to 82 years of age) were no different from those in younger age

groups. The incidence rates for adverse events and laboratory abnormalities were also not different from those seen in other age groups.

**ADVERSE REACTIONS:** The following have been reported as events in clinical trials or in the routine management of patients treated with oral ZANTAC®. The relationship to ZANTAC therapy has been unclear in many cases. Headache, sometimes severe, seems to be related to ZANTAC administration.

**Central Nervous System:** Rarely, malaise, dizziness, somnolence, insomnia, and vertigo. Rare cases of reversible mental confusion, agitation, depression, and hallucinations have been reported, predominantly in severely ill elderly patients.

**Cardiovascular:** Rare reports of tachycardia, bradycardia, and premature ventricular beats.

**Gastrointestinal:** Constipation, diarrhea, nausea/vomiting, and abdominal discomfort/pain.

**Hepatic:** In normal volunteers, SGPT values were increased to at least twice the pretreatment levels in 6 of 12 subjects receiving 100 mg qid IV for seven days, and in 4 of 24 subjects receiving 50 mg qid IV for five days. With oral administration there have been occasional reports of reversible hepatitis, hepatocellular or hepatocanalicular or mixed, with or without jaundice.

**Musculoskeletal:** Rare reports of arthralgias.

**Hematologic:** Rare reports of reversible leukopenia, granulocytopenia, thrombocytopenia, and pancytopenia.

**Endocrine:** Controlled studies in animals and man have shown no stimulation of any pituitary hormone by ZANTAC and no antiandrogenic activity, and cimetidine-induced gynecomastia and impotence in hypersecretory patients have resolved when ZANTAC has been substituted. However, occasional cases of gynecomastia, impotence, and loss of libido have been reported in male patients receiving ZANTAC, but the incidence did not differ from that in the general population.

**Integumental:** Rash, including rare cases suggestive of mild erythema multiforme, and, rarely, alopecia.

**Other:** Rare cases of hypersensitivity reactions (eg, bronchospasm, fever, rash, eosinophilia) and small increases in serum creatinine.

**DOSE AND ADMINISTRATION: Active Duodenal Ulcer:** The current recommended adult oral dosage is 150 mg twice daily. An alternate dosage of 300 mg once daily at bedtime can be used for patients in whom dosing convenience is important. The advantages of one treatment regimen compared to the other in a particular patient population have yet to be demonstrated.

**Maintenance Therapy:** The current recommended adult oral dosage is 150 mg at bedtime.

**Pathological Hypersecretory Conditions (such as Zollinger-Ellison Syndrome):** The current recommended adult oral dosage is 150 mg twice a day. In some patients it may be necessary to administer ZANTAC® 150-mg doses more frequently. Doses should be adjusted to individual patient needs, and should continue as long as clinically indicated. Doses up to 6 g/day have been employed in patients with severe disease.

**Benign Gastric Ulcer:** The current recommended adult oral dosage is 150 mg twice a day.

**GERD:** The current recommended adult oral dosage is 150 mg twice a day.

See full prescribing information for dosage adjustment for patients with impaired renal function.

**HOW SUPPLIED:** ZANTAC® 300 Tablets (ranitidine hydrochloride equivalent to 300 mg of ranitidine) are yellow, capsule-shaped tablets embossed with "ZANTAC 300" on one side and "Glaxo" on the other. They are available in bottles of 30 (NDC 0173-0393-40) and unit dose packs of 100 tablets (NDC 0173-0393-47).

ZANTAC® 150 Tablets (ranitidine hydrochloride equivalent to 150 mg of ranitidine) are white tablets embossed with "ZANTAC 150" on one side and "Glaxo" on the other. They are available in bottles of 60 tablets (NDC 0173-0344-42) and unit dose packs of 100 tablets (NDC 0173-0344-47).

Store between 15° and 30°C (59° and 86°F) in a dry place. Protect from light. Replace cap securely after each opening.

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## Glaxo

Glaxo Inc.  
Research Triangle Park, NC 27709

# Motrin<sup>®</sup> 800 TABLETS mg

ibuprofen



Extra strength  
Convenience  
Economy

Upjohn



A Century  
of Caring  
1886-1986

Before prescribing, see complete prescribing information in SK&F CO. literature or PDR. The following is a brief summary.

**\* WARNING**

This drug is not indicated for initial therapy of edema or hypertension. Edema or hypertension requires therapy titrated to the individual. If this combination represents the dosage so determined, its use may be more convenient in patient management. Treatment of hypertension and edema is not static, but must be reevaluated as conditions in each patient warrant.

**Contraindications:** Concomitant use with other potassium-sparing agents such as spironolactone or amiloride. Further use in anuria, progressive renal or hepatic dysfunction, hyperkalemia. Pre-existing elevated serum potassium. Hypersensitivity to either component or other sulfonamide-derived drugs.

**Warnings:** Do not use potassium supplements, dietary or otherwise, unless hypokalemia develops or dietary intake of potassium is markedly impaired. If supplementary potassium is needed, potassium tablets should not be used. Hyperkalemia can occur, and has been associated with cardiac irregularities. It is more likely in the severely ill, with urine volume less than one liter/day, the elderly and diabetics with suspected or confirmed renal insufficiency. Periodically, serum  $K^+$  levels should be determined. If hyperkalemia develops, substitute a thiazide alone, restrict  $K^+$  intake. Associated widened QRS complex or arrhythmia requires prompt additional therapy. Thiazides cross the placental barrier and appear in cord blood. Use in pregnancy requires weighing anticipated benefits against possible hazards, including fetal or neonatal jaundice, thrombocytopenia, other adverse reactions seen in adults. Thiazides appear and triamterene may appear in breast milk. If their use is essential, the patient should stop nursing. Adequate information on use in children is not available. Sensitivity reactions may occur in patients with or without a history of allergy or bronchial asthma. Possible exacerbation or activation of systemic lupus erythematosus has been reported with thiazide diuretics.

**Precautions:** The bioavailability of the hydrochlorothiazide component of 'Dyazide' is about 50% of the bioavailability of the single entity. Theoretically, a patient transferred from the single entities of triamterene and hydrochlorothiazide may show an increase in blood pressure or fluid retention. Similarly, it is also possible that the lesser hydrochlorothiazide bioavailability could lead to increased serum potassium levels. However, extensive clinical experience with 'Dyazide' suggests that these conditions have not been commonly observed in clinical practice. Angiotensin-converting enzyme (ACE) inhibitors can elevate serum potassium; use with caution with 'Dyazide'. Do periodic serum electrolyte determinations (particularly important in patients vomiting excessively or receiving parenteral fluids, and during concurrent use with amphotericin B or corticosteroids or corticotropin [ACTH]). Periodic BUN and serum creatinine determinations should be made, especially in the elderly, diabetics or those with suspected or confirmed renal insufficiency. Cumulative effects of the drug may develop in patients with impaired renal function. Thiazides should be used with caution in patients with impaired hepatic function. They can precipitate coma in patients with severe liver disease. Observe regularly for possible blood dyscrasias, liver damage, other idiosyncratic reactions. Blood dyscrasias have been reported in patients receiving triamterene, and leukopenia, thrombocytopenia, agranulocytosis, and aplastic and hemolytic anemia have been reported with thiazides. Thiazides may cause manifestation of latent diabetes mellitus. The effects of oral anticoagulants may be decreased when used concurrently with hydrochlorothiazide; dosage adjustments may be necessary. Clinically insignificant reductions in arterial responsiveness to norepinephrine have been reported. Thiazides have also been shown to increase the paralyzing effect of nondepolarizing muscle relaxants such as tubocurarine. Triamterene is a weak folic acid antagonist. Do periodic blood studies in cirrhotics with splenomegaly. Antihypertensive effects may be enhanced in post-sympathectomy patients. Use cautiously in surgical patients. Triamterene has been found in renal stones in association with the other usual calculus components. Therefore, 'Dyazide' should be used with caution in patients with histories of stone formation. A few occurrences of acute renal failure have been reported in patients on 'Dyazide' when treated with indomethacin. Therefore, caution is advised in administering nonsteroidal anti-inflammatory agents with 'Dyazide'. The following may occur: transient elevated BUN or creatinine or both, hyperglycemia and glycosuria (diabetic insulin requirements may be altered), hyperuricemia and gout, digitalis intoxication (in hypokalemia), decreasing alkali reserve with possible metabolic acidosis. 'Dyazide' interferes with fluorescent measurement of quinidine. Hypokalemia is uncommon with 'Dyazide', but should it develop, corrective measures should be taken such as potassium supplementation or increased dietary intake of potassium-rich foods. Corrective measures should be instituted cautiously and serum potassium levels determined. Discontinue corrective measures and 'Dyazide' should laboratory values reveal elevated serum potassium. Chloride deficit may occur as well as dilutional hyponatremia. Concurrent use with chlorpropamide may increase the risk of severe hyponatremia. Serum PBI levels may decrease without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. 'Dyazide' should be withdrawn before conducting tests for parathyroid function. Thiazides may add to or potentiate the action of other antihypertensive drugs. Diuretics reduce renal clearance of lithium and increase the risk of lithium toxicity.

**Adverse Reactions:** Muscle cramps, weakness, dizziness, headache, dry mouth; anaphylaxis, rash, urticaria, photosensitivity, purpura, other dermatological conditions; nausea and vomiting, diarrhea, constipation, other gastrointestinal disturbances; postural hypotension (may be aggravated by alcohol, barbiturates, or narcotics). Necrotizing vasculitis, paresthesias, icterus, pancreatitis, xanthopsia and respiratory distress including pneumonitis and pulmonary edema, transient blurred vision, sialadenitis, and vertigo have occurred with thiazides alone. Triamterene has been found in renal stones in association with other usual calculus components. Rare incidents of acute interstitial nephritis have been reported. Impotence has been reported in a few patients on 'Dyazide', although a causal relationship has not been established.

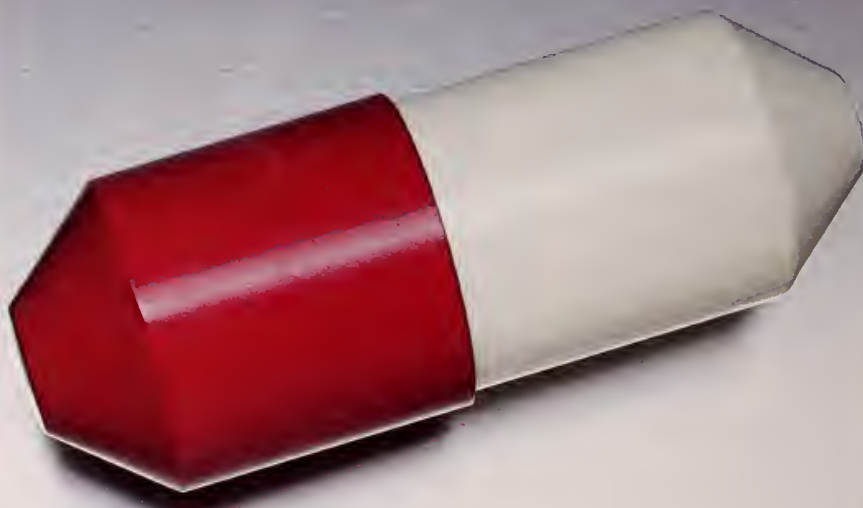
**Supplied:** 'Dyazide' is supplied as a red and white capsule, in bottles of 1000 capsules; Single Unit Packages (unit-dose) of 100 (intended for institutional use only); in Patient-Pak™ unit-of-use bottles of 100.

BRS-DZ:L42

# In Hypertension\*... When You Need to Conserve $K^+$

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Serum  $K^+$  and BUN should be checked periodically (see Warnings and Precautions)



Potassium-Sparing

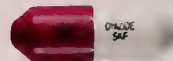
**DYAZIDE®**

25 mg Hydrochlorothiazide/50 mg Triamterene/SKF

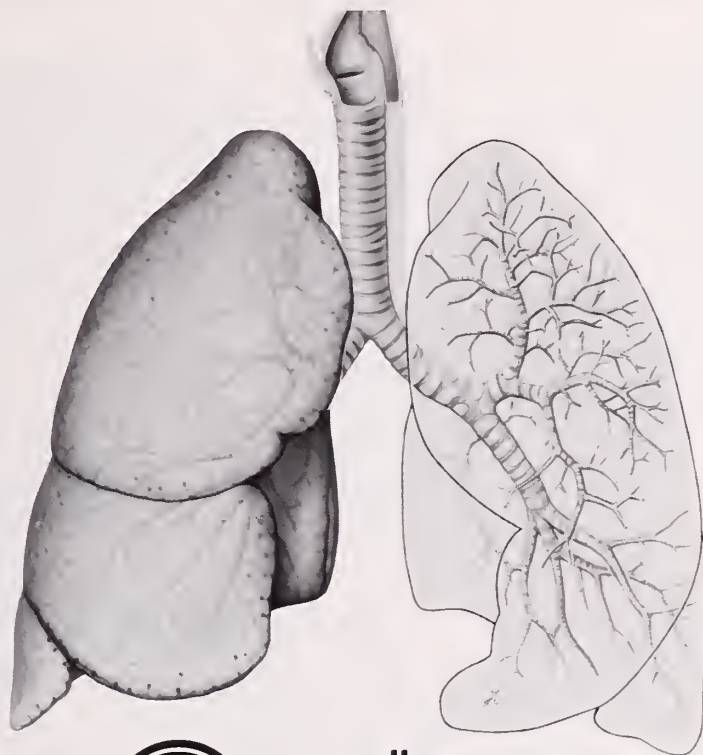
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red and white  
Dyazide® capsule:  
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# Consider the causative organisms...



**Ceclor<sup>®</sup>**  
ceftiofur

**250-mg Pulvules<sup>®</sup> t.i.d.**

**offers effectiveness against  
the major causes of bacterial bronchitis**

***Haemophilus influenzae*, *H influenzae*, *Streptococcus pneumoniae*, *Streptococcus pyogenes***  
(ampicillin-susceptible) (ampicillin-resistant)

**Note:** Ceclor<sup>®</sup> is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

#### **Ceclor<sup>®</sup> (ceftiofur)**

**Summary.** Consult the package literature for prescribing information.

**Indications:** Lower respiratory infections, including pneumonia, caused by susceptible strains of *Streptococcus pneumoniae*, *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

**Contraindications:** Known allergy to cephalosporins.

**Warnings:** CECLOR SHOULD BE ADMINISTERED CAUTIOUSLY TO PENICILLIN-SENSITIVE PATIENTS. PENICILLINS AND CEPHALOSPORINS SHOW PARTIAL CROSS-ALLERGENICITY. POSSIBLE REACTIONS INCLUDE ANAPHYLAXIS.

Administer cautiously to allergic patients.

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics. It must be considered in

associated diarrhea. Colon flora is altered by broad-spectrum antibiotic treatment, possibly resulting in antibiotic-associated colitis.

#### **Precautions:**

- Discontinue Ceclor in the event of allergic reactions to it.
- Prolonged use may result in overgrowth of nonsusceptible organisms.
- Positive direct Coombs' tests have been reported during treatment with cephalosporins.
- In renal impairment, safe dosage of Ceclor may be lower than that usually recommended. Ceclor should be administered with caution in such patients.
- Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis.
- Safety and effectiveness have not been determined in pregnancy, lactation, and

penetrates mother's milk. Exercise caution in prescribing for these patients.

#### **Adverse Reactions:** (percentage of patients)

Therapy-related adverse reactions are uncommon. Those reported include:

- Gastrointestinal (mostly diarrhea): 2.5%.
- Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment.
- Hypersensitivity reactions (including morbilliform eruptions, pruritus, urticaria, erythema multiforme, serum-sickness-like reactions): 1.5%; usually subside within a few days after cessation of therapy. These reactions have been reported more frequently in children than in adults and have usually occurred during or following a second course of therapy with Ceclor. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance

- Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.
- Other: eosinophilia, 2%; genital pruritus or vaginitis, less than 1%.

#### **Abnormalities in laboratory results of uncertain etiology**

- Slight elevations in hepatic enzymes.
- Transient fluctuations in leukocyte count (especially in infants and children)
- Abnormal urinalysis; elevations in BUN or serum creatinine
- Positive direct Coombs' test
- False-positive tests for urinary glucose with Benedict's or Fehling's solution and Clinitest<sup>®</sup> tablets but not with Tes-Tape<sup>®</sup> (glucose enzymatic test strip, Lilly)

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## Wanted: More Plaintiffs

It is a "generally accepted fact," a "well known truth," and a "widely reported statistic." Depending on whose crystal ball you use as a source of information, there are from ten to eighty thousand physicians who are impaired and/or incompetent but practicing medicine in this country today.

The editor of a national news magazine wrote that it is true. The editor of a prestigious professional medical journal wrote that it is true. A secretary of the President's cabinet has stated that it is true. A chorus of voices from licensing agencies, national medical organizations, and every category of the media chant that it is true.

Who can deny such overwhelming albeit purely conjectural evidence? What factual evidence could support an effective denial? What purpose would denial serve?

Simple, reasonable probability supports the allegation that there *are* thousands of impaired and incompetent physicians practicing medicine in this nation today. The actual number of them has never been and can never be determined precisely. Public arguments about the size of the problem are pointless and misdirected — pure, superfluous rhetoric.

If the complainers ended their lamentations with speculations about numbers, there would be nothing newsworthy about their spoken and written statements. Unfortunately they do not stop with simple recitations of estimates and opinions. They go further into the realm of factless fantasy and reveal the reasons these incompetents continue to practice, unhampered. Not surprisingly, every reason presented indicts the medical profession. We do not police ourselves. We participate in a continuing conspiracy of silence. We refuse to clean our own house. We maintain membership in some mythical organization called "the Good Old Boys Club." We won't testify against a colleague. We refuse to get involved. We protect each other instead of our patients.

Such charges are pure, unadulterated nonsense. They do, however, heap more slander and libel on our profession, thus achieving popularity and newsworthiness. Had they bothered to be honest, every indi-

vidual promoting such defamations would have abstained. They would admit that it is impossible to initiate or even participate in any tort action without subjecting oneself to the liabilities of a plaintiff: endless, unpredictable hours in a courtroom, on the witness stand, responding to the insulting innuendos of a defense attorney, defending your integrity, your own competency, your motives. All of this in addition to paying thousands of dollars in attorney's fees, being out of your office for days, weeks, even months, and surviving the stress, notoriety, and exposure of a trial that could drag on for months, not to mention the inevitable appeals which could drag on for years.

An informed, intelligent plaintiff realizes fully that the outcome could, in addition to exonerating the defendant, impugn your reputation, make you an object of scorn, and plunge you into bankruptcy. It could even lead to your subsequent prosecution for violating the antitrust laws, participating in a conspiracy, or promoting malicious slander.

Such a scenario is neither fiction nor fallacy. Law journals and records contain more than sufficient documentation of precisely such events.

In view of these experiences, who will volunteer as an accuser? How about one of those who so eagerly and publicly volunteer as critics of the medical profession's policing activities? Instead of condemning the integrity of the medical profession by citing speculative numbers of anonymous incompetents, why don't our critics name some of them and join the ranks of the few but courageous plaintiffs?

Apparently, they do not hesitate for lack of evidence. They have not found it necessary to use such modifiers as "possibly" or "allegedly." They call physicians incompetent with no equivocation. They surely would have no difficulty finding an incompetent physician; with so many thousands of them in practice, there must be one or more just around any corner. Why then are there so many critics and so few plaintiffs?

Critics are plentiful. What we need more of is plaintiffs.

— MRJ

## PRESIDENT'S PAGE

**A**t this time we are all immersed in the American process of electing our governmental officials.

These are always important decisions, but in recent years these decisions have become even more vital and more critical for us in the medical profession.

Your state medical society's Legislative Council, as well as our OMPAC Committee, have spent a great deal of time trying to evaluate effectiveness and friendliness of the various candidates, both challengers and incumbents, for the various state offices throughout the entire state. We have developed a list of people that we think are receptive to the ideals of medicine. They do not always vote the way we would like them to vote, but at least they will listen and frequently support the things that we think are important.

The problem of tort reform, of course, this year is of primary interest to all of us, and in general we



are very concerned with the candidates' stand on this important piece of legislation.

The list of these individuals is in this JOURNAL beginning on page 771. All of us must take the time and effort to support these candidates in our districts, with whatever money and aid we can provide. Often personal contact to let them know that we are behind them and what we are interested in for the benefit of Oklahoma will tip a legislator one way or the other.

Let us hope that a more enlightened and sympathetic legislature will correct some of the inequities and problems in our treatment of our patients in this day and age.

A handwritten signature in dark ink that reads "Norman L. Dunitz, MD." The signature is written in a cursive style with a large initial 'N' and 'D'.

Norman L. Dunitz, MD

# PCBs — An Epidemic of Concern

ROY L. DeHART, MD

**PCBs — compounds with very low acute toxicity — have been misrepresented to many as dangerous poisons, causing undue anxiety and an epidemic of concern.**

**P**olychlorinated biphenyls (PCBs) have generated significant interest with regard to potential health effects among many concerned persons in the United States.<sup>1-3</sup> The State of Oklahoma has not been spared this concern.

On April 16, 1982, an explosion occurred at the Federal Building in Tulsa involving transformer equipment, with the subsequent release of PCBs. On December 29, 1983, and again on May 24, 1984, transformer explosions in an eight-story Tulsa office building resulted in the release of PCBs. Additional exposures have occurred in residential areas where large capacitors mounted on power poles have been damaged, resulting in PCB leaks and contamination. In the summer of 1985, a major air frame manufacturer, Rockwell International, reported PCB contamination of the plant's air conditioning system. These incidents and others have received widespread media coverage resulting in thousands of people becoming concerned about their health or the health of family members with regard to PCB contamination. Many have turned to their personal physicians for advice and reassurance.

This epidemic of concern has resulted in allegations of major illnesses resulting from possible PCB exposures. Tens of thousands of dollars have been expended for medical examinations, some involving sophisticated toxicological tests and neurodiagnostic assessments. Reportedly, evaluations have taken up to fourteen hours to conduct, at a total per patient cost approaching ten thousand dollars. This epidemic of concern has further been expressed by the filing of over one billion dollars in lawsuits in the Tulsa area alone. In dealing with any epidemic, the medical practitioner who becomes involved either by choice or circumstance must understand its cause, whether biological, physical, chemical, or psychological (ignorance and fear).

## Polychlorinated Biphenyl

Polychlorinated biphenyl is not a single chemical compound, but refers to 209 possible chloribiphenyl isomers with differing numbers of chlorine atoms placed on the basic biphenyl structure (Fig 1).<sup>4</sup> These chemicals were first compounded in the late 1800s and became commercially useful in 1929. As is evident, PCBs belong to the class of halogenated aromatic hydrocarbons, all of which are foreign to man's normal metabolism.

The PCBs have characteristics which make them attractive to industry. In form they range from light oily fluids to heavy oils, greases, and waxes. They are nonflammable, are readily manufactured, are soluble in oil, can maintain a viscosity that serves as a lubricant, have a low volatility, are chemically

Roy L. DeHart, MD, MPH, Professor and Director, Division of Occupational Medicine, Department of Family Medicine, University of Oklahoma Health Sciences Center, PO Box 26901, Oklahoma City, OK 73190.

stable, and possess a high dielectric constant. PCBs are used in two types of electrical equipment: transformers, which raise or lower the voltage on a power line; and capacitors which, located on utility poles, help maintain constant voltage in buildings.

Although more expensive than other transformers using oil as a heat transfer fluid, the PCB-containing transformers were specifically designed for use in enclosed areas, such as buildings, to reduce the risk of transformer fires. Although PCB-containing transformers have overheated or exploded, few have ignited, thus reducing the hazard of a building fire.

These characteristics have resulted in other wide uses in industry that range from cosmetics to insulators, plasticizers to heat-transfer fluids. A list of common uses for PCBs is provided in the accompanying table.

In 1977 Hecht<sup>5</sup> estimated that, since the 1930s, over 1.25 billion pounds of PCBs had been produced in the United States. Of that production, it was estimated that 750 million pounds were still in use and 450 million pounds had found their way into the general environment. It was the discovery of a major environmental contamination with PCBs that, in part, led to the passage of the Toxic Substance Control Act of 1976.

### Pharmacokinetics

Absorption of PCBs can occur via the skin, the respiratory tract, or the gastrointestinal tract. Distribution throughout the body is rapid and disposition occurs primarily in fatty tissues. The metabolic degradation of the product depends on the molecular structure of the particular PCB. Generally, PCBs reside in the body fat and are gradually released in the circulatory system over a prolonged time period.

In the environment, the compound, because of its

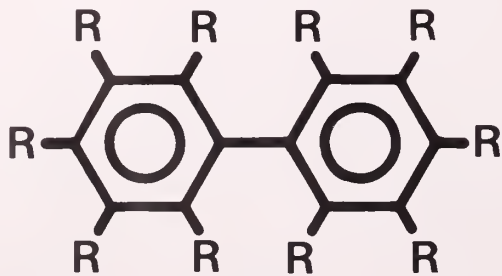
fat solubility, becomes biomagnified in the food chain. Environmental analyses have revealed PCBs to be ubiquitous contaminants of soil, air, water, and aquatic sediments. Samples from remote arctic sites have tested positive for PCBs. Because of their chemical stability, PCBs, once introduced, remain in the environment. As a consequence, in 1977 the Environmental Protection Agency (EPA) issued a ban on the further manufacturing of PCBs, thus reducing both occupational exposure and environmental contamination.<sup>6</sup> The ban did not extend to equipment containing PCBs that was manufactured prior to 1977. Thus, numerous transformers, capacitors, and other electrical equipment containing PCBs exist in industry, office buildings, schools, and homes. Continued occupational and environmental exposure can be expected to occur on a sporadic basis. The National Institute for Occupational Safety and Health (NIOSH) estimates that twelve thousand workers currently face potential exposure to PCBs in the work place.<sup>7</sup>

Within the body, the liver is the primary organ for biotransformation through hydroxylation and conjugation with glucuronic acid. Excretion of PCB metabolic products is generally slow. It is recognized that the higher the exposure level, the higher the blood concentration of PCBs; also, the higher the environmental concentration or the longer the exposure, the longer the blood levels of PCBs remain elevated in the body fat.<sup>8</sup> Blood PCB concentrations have demonstrated a close correlation to adipose tissue levels and consequently to the total body burden. This assumes first-order thermodynamic partitioning between the adipose tissue and blood lipids.<sup>9</sup>

Emmitt,<sup>9</sup> of Johns Hopkins, has reported that of the 209 possible congeners, over 100 have been detected in human tissue. The pharmacokinetics differ depending on structure, with some inducing enzyme changes.

### Toxicity

**Acute.** Animal studies have clearly demonstrated that the potential for toxicity is low when PCB is administered as a single dose. Experience in industry has substantiated the animal studies and has generally been associated with minimal toxicity. In rodents the acute oral LD<sub>50</sub> ranges from one to ten grams per kilo of body weight. According to the American Industrial Hygiene Association classification for acute toxicity, PCBs are classified as "slightly toxic to practically non-toxic." Reported symptoms after occupational exposures have included mild irritation of the skin and eyes where air levels exceed 0.1 mg/m<sup>3</sup>, with



**Figure 1.** — Polychlorinated biphenyls (PCBs). R represents the varying numbers and positions of chlorine atoms attached to the biphenyl nucleus.

Table. — Major Uses of Polychlorinated Biphenyls (PCBs)

Adhesives	Flame retardants
Ballasts in lights	Heat-transfer fluids
Capacitors	Hydraulic fluids
Carbonless paper	Inks
Casting wax	Lipsticks
Caulking compounds	Lubricants
Cooling fluids	Paints
Cosmetics	Paper
Cutting oils	Plasticizers
Dust control agents	Transformers
Extenders for pesticides	Varnishes
Fillers	

unbearable irritation occurring above 10 mg/m<sup>3</sup>.<sup>11</sup> Thus, it is extremely unlikely that a casual single-dose exposure to PCBs will result in any but minor acute symptoms.

**Chronic.** The mass population exposures that have occurred as a result of accidents in Japan and Taiwan raised the level of concern about toxic manifestations of PCB. The accidents were similar, and the manifestations of toxicity were likewise similar. In Japan, at least 1,600 people consumed rice oil that was contaminated with PCBs because of a failure in a heat exchange system. The average amount of PCBs ingested was estimated to be two grams, with a minimum of approximately one-half gram. This exposure dose is considered higher than most occupational exposures.

A major difference in this exposure compared to occupational exposures was that the PCBs were ingested as opposed to inhaled or skin-absorbed. Symptoms began to appear following a latent period of five to six months. The signs and symptoms were repetitive among those exposed, thus creating a syndrome that has become known as "Yusho" (rice oil) Disease. Until recently it was assumed that these symptoms were attributable to the PCB ingestion; however, subsequent investigations have established that the syndrome is most probably associated with a far more toxic compound — furans (Fig 2) — produced when rice oil is heated to fry foods.<sup>4,11</sup> Thus, the original concern about PCBs and concomitant health effects was misplaced.

Chronic exposure to PCBs appears to alter liver metabolism, and chloracne becomes manifest whether the PCB is a skin contaminant or an inhalant. Excessive palmar sweating and hypersecretion of the meibomian glands are associated with levels of PCB exceeding 100 parts per billion (ppb) in the blood. However, it should be pointed out that with the exception of chloracne, no serious adverse effects

have been consistently linked to chronic PCB exposure.<sup>12</sup> NIOSH has found no relationship between cancer mortality of industrial workers and exposure to PCBs.<sup>7</sup> However, these results remain controversial, as there are always objections that can be raised to in-plant occupational investigations, as the plants will always fail to meet the rigors of a laboratory-conducted matched cohort prospective study.

Studies are ongoing among employees in occupational groups that have sustained long-term, chronic exposure to PCBs. This should help resolve the complaints of small numbers and inadequate time to allow for latency which plague the current human exposure data.

Investigations of chronic exposures in animals have revealed a diversity of toxic effects. Skin and hepatic disorders are evident. Enzyme induction appears to occur in the liver and other organs. Immunosuppression has been suggested. Alterations of reproduction, including spontaneous abortion, have been evident. In a variety of test animals, no specific teratogenic effects of PCBs have been observed, although fetotoxic effects have been well documented. Carcinogenic effects in laboratory animals have been documented.<sup>13</sup> In reviewing animal studies, the physician must keep in mind the research exposure patterns used in these studies. Typically, the compound is fed to an animal species on a daily basis at a level just below that producing acute toxicity. The applicability of these animal studies to the pharmacokinetics of the compound in humans (at exposure levels typical in the industrial setting) is conjecture.

## Human Effects

When discussing the known toxic effects of PCBs, concern focuses on the effects of chronic exposure. Very high initial exposures, or lower levels over extended periods, that exceed by one-hundred-fold the

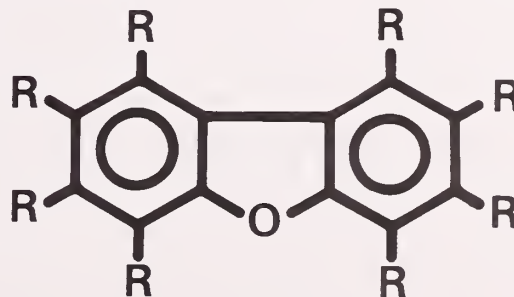


Figure 2. — Chlorinated dibenzofurans (PCDFs). R equals possible positions of chlorine atoms.

maximum permissible dose can result in a number of signs and symptoms. As is typical of many of the halogenated hydrocarbons, acnelike skin eruptions (chloracne) may become manifest. This condition occurs months or years following repeated exposures. Other skin manifestations may include pigmentation of the skin and nails, a noticeable eye discharge, puffiness of the eyelids, and a highlighting of hair follicles. These dermatological manifestations have a direct dose-time relationship and normally resolve with removal from exposure.<sup>7</sup> There has been evidence reported that individuals chronically exposed to PCBs experience a number of biochemical abnormalities including elevated serum transaminase, gamma-glutamyltranspeptidase (GGPT), and triglycerides.<sup>4</sup> The question of blood lipid levels and the relationship to PCBs remains unclear. It is suggested that blood PCB levels are increased when there are available blood lipids to transport these chemicals, and thus the PCBs are not the source but the result of these elevated levels.<sup>14</sup> With the exception of chloracne, no serious adverse effects to human health have been consistently linked to acute or chronic exposure to PCBs.

## **More deaths have been reported from bee stings, lightning strikes, and hot dog strangulations than from exposures to PCBs.**

The federal regulatory agencies have declared PCBs a "potential human carcinogen." However, this ruling is not based on epidemiological evidence with regard to human exposure, but rests on a variety of laboratory animal investigations. The extrapolation from animal data may induce considerable flaws in determining human risk assessment. In these investigations, the animal species is fed PCBs far in excess of typical industrial exposures experienced by humans. Numerous studies among industrial workers chronically exposed for years to PCBs have failed to establish an epidemiological link to human cancer.<sup>2,7,13,15</sup> If one accepts the concept of a dose response curve, and in other clinical manifestations PCBs respond appropriately, then casual exposure to PCBs among general population groups would be ex-

pected to have a zero to infinitesimal risk attributable to that exposure. Frequently, in the PCB literature, it is stated that enough is not yet known with regard to PCBs and human health effects; I suggest that it is a rare event indeed when enough is known to provide absolute assurance of safety or to prove a "noneffect" or "nonevent."

Inasmuch as the potential health hazards of PCBs were not apparent until the past decade, handling transformer fluids was casual, with few or no specific handling procedures in effect for the greater part of the past exposure period of over forty years. The typical work environment as described by an engineer follows:

I've got it all over me, this so called PCB oil or transformer insulating fluid. I've had my arms in the stuff all the way up to the shoulders. All I ever did when I got the oil on me was to wipe it off with a shop rag. Lots of people have worked with PCBs for years, getting it on their hands and arms. We had big electric transformers; we would take PCB oil samples out of the transformers to a testing station. It wasn't unusual to get the oil smeared on your hands or spill some on the ground. To reach an internal part of the transformer or to check connections meant getting your hands and arms into the fluid. No one ever worried about this. There are many older electricians and engineers in Tulsa, Oklahoma, who have practically bathed in it. It was common for workers who repaired electric utility transformers to get the PCB fluid all over them.<sup>16</sup>

A retrospective, cohort, mortality study of 2,567 workers in two capacitor manufacturing plants was recently completed by NIOSH. No statistically significant standardized mortality ratio for any cause of death among exposed workers was found. There was no relationship between mortality by case and length of exposure to PCBs.<sup>17</sup>

Eighty-six experienced electrical employees had plasma level elevations of PCBs averaging 33.4 ppb, with a range of 10ppb to 312 ppb, twice the level of nonexposed controls. Transient symptoms of skin and eye irritation and occasional chloracne were reported. There was a relative absence of significant physical findings.<sup>12</sup> A recent comprehensive study of capacitor manufacturing workers by Fishbein et al<sup>15</sup> was notable for its relative absence of physical findings, other than a high prevalence of dermatological abnormalities, despite a mean plasma PCB level of 177 ppb (N = 288). Baker et al<sup>8</sup> reported no symptoms or physical findings of organ toxicity in a different group of PCB-exposed capacitor workers whose mean plasma PCB level was 75.1 ppb (N = 18). Four adult women working in a capacitor factory experienced

chronic exposure, with blood levels for PCBs between 40 ppb and 70 ppb in 1974, dropping to 21 ppb and 50 ppb by 1979. The elimination rate was estimated to be 9.2% per year. None of these women experienced clinical symptoms relative to her PCB exposure.<sup>9</sup>

The Environmental Protection Agency estimates that 90% of the US population has detectable levels of PCBs in their blood.<sup>13</sup> A recent survey of individuals undergoing a preplacement medical examination for a California corporation analyzed blood for PCBs. Among the 738 participants, the blood PCBs concentrations ranged from 1 ppb to 37 ppb, with a median of 4 ppb.<sup>18</sup> Trace amounts of PCBs are found in human blood, fat, and milk. Background level is typically less than 20 ppb in blood and 1 ppm to 2 ppm in adipose tissue.<sup>19</sup>

Current standards promulgated by the Occupational Safety and Health Administration (OSHA) allows one milligram per cubic meter of air of PCBs, while NIOSH recommends one microgram per cubic meter of air. The OSHA value is the one now establishing maximum exposure levels based on occupational experience of a forty-hour work week over a working lifetime. Permissible PCB contamination of substances such as oils or soils can be as high as 50 ppm.<sup>6</sup>

On February 5, 1985, the Binghamton State Office Building, an eighteen-story office complex in upstate New York, was contaminated by a PCB transformer fire. A similar event had previously occurred at One Market Plaza in San Francisco when five floors of the twenty-four-story complex were contaminated by a transformer fire involving PCBs. These events are similar to situations which have occurred over the last several years in Tulsa.

When reading a report regarding building contamination with PCBs, it is important that the values provided be properly interpreted. If the contamination is reported as an air sample ( $\text{Xugm}/\text{m}^3$ ), then contact with building inhabitants may occur. If the report is a surface wipe sample ( $\text{Xugm}/\text{m}^2$ ), then there is little likelihood of tenant contact, as most wipe

samples are taken along the floor-wall junction, in corners, or off cable junction boxes in the transformer vault. The typical occupant has no contact with these areas.

One question has not been answered with regard to building contamination: What is the "background"

**Ninety percent  
of the population  
will have a  
background PCB blood level  
of 5 ppb to 10 ppb.**

level in the so-called noncontaminated buildings in the area? As PCBs are ubiquitous, it is possible that the clean-up standards of buildings such as the one in San Francisco may demand a standard higher than that currently existing in office buildings in the area.

Complicating PCB transformer fires are the very small amounts of other contaminants generated. PCBs, when undergoing incomplete combustion, may produce small amounts of furans and dioxins (Fig 3). Although a form of dioxin has been described as "one of the most toxic substances known to man" and is clearly fatal to guinea pigs, not a single human death attributable to acute exposure has been reported in the available medical literature. More deaths have been reported annually from bee stings, dog bites, lightning strikes, and hot dog strangulations than from documented acute exposure to either PCBs or dioxin, one of the thermal by-products of PCBs.

### Patient Management

The physician who is confronted with a patient worried about PCB exposure has an opportunity to effectively intercede in this epidemic of concern. As always, the physician should obtain a history that delineates the circumstances of the PCB exposure. Once it is established that such an exposure may have occurred, then a review of systems and a categorization of symptoms that the patient attributes to the exposure should be undertaken. In conducting the physical examination, give special attention to the skin, looking for possible manifestations of dermatological disorders. A neurological screening

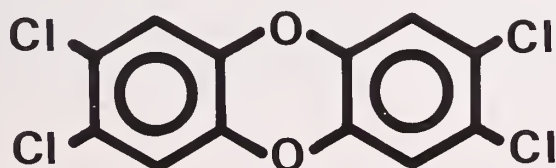


Figure 3. — Dioxin; 2, 3, 7, 8 TCDD.

examination would also be appropriate. Other elements of the physical examination would depend not so much on the exposure but on the general health status of the patient and the circumstances of the patient's last examination. For some patients this may serve as an excellent opportunity for a complete health assessment.

Unless there is evidence to suggest PCB effects, no special tests are required. However, if the emotional status of the patient is indicative of considerable concern, it may be helpful to obtain a PCB blood level from an appropriately approved regional laboratory as well as a CBC and liver function screen. In interpreting these results for the patient, it is important to advise beforehand that the majority of the American population currently has measurable levels of PCBs in the blood. The patient should be informed that 90% of the population will have a background PCB blood level of 5 ppb to 10 ppb. By advising the patient of this in advance, it becomes far easier to report measurable levels in the patient's blood.

The most important contribution that a physician can make in managing this epidemic of concern is understanding and accurate information. Most patients will come to you because of concern about what they have read, seen, or been told. Much of the information will be incorrect or misinterpreted. In those cases, correct information should be provided. An occasional patient may present as part of a litigious situation. In such cases the patient may very well not be interested in the "good news"; nevertheless, the physician has the obligation to inform and educate.

Healthy workers with only a single acute exposure, or those with a history of chronic low-level exposures and normal findings, require no follow-up. Those with elevated liver enzymes, abnormal physical findings, or elevated blood or fat PCB levels, should have a six-month follow-up examination. Consultation with a clinical toxicologist or occupational medicine specialist may be appropriate.

In dealing with an epidemic, those individuals who have experienced potential exposure are concerned about becoming a victim of the epidemic. A risk analysis can be of help to the physician in explaining the odds of an individual's falling victim to the disease process. The individual who has sustained a casual exposure to PCB can be reassured as

to the unlikelihood of possible acute and future illnesses resulting from the exposure. For the individual who has sustained a more long-term exposure in the work environment, the data on chronic occupational exposures is likewise reassuring. The risk to life and health from the normal experiences of daily living exceed any potential risk related to casual exposures to PCB. Smoking a pack of cigarettes per day or failing to use restraint systems when driving introduces risks far greater than those which might be attributable to PCB exposure. □

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# Evaluation of Pall BB-50T Bacteria Filter in a Volume Ventilator Circuit

D. J. FLOURNOY, PhD

**A new hydrophobic filter (BB-50T, Pall Biomedical Products Corp, Glen Cove, NY) was evaluated as to filtration efficacy. The filter was also used to quantitate bacterial contamination throughout the circuitry of an MA-1 volume ventilator. Results show that test organisms are capable of passing from an updraft nebulizer placed in the inhalation side about six inches from a Y-piece, through the circuitry to the spirometer in 30 minutes. The filter was efficient (>99%) in trapping test organisms throughout the system.**

Several reports of atmospheric bacterial contamination originating from respiratory therapy equipment<sup>1-3</sup> have prompted the use of filters to trap emitted contaminants. It is important that organisms not be emitted into the air since other patients and hospital personnel could become infected with or transmit these agents. With this in mind, a new filter, BB-50T (Pall Biomedical Products Corp., Glen Cove, NY), seen in Figure 1, was evaluated for its ability to remove bacteria from air passing through the circuitry of an MA-1 volume ventilator (Puritan-Bennett Corp., Kansas City, Mo). Enumeration of contaminating test organisms throughout the ventilator circuitry was also studied to show areas in the circuitry where organisms were most concentrated at various times.

## Materials and Methods

Experiments were designed to quantitate contamination by the test organisms at different sites in the circuitry of an MA-1 volume ventilator and to determine the efficiency of the filter in trapping organisms. All ventilator settings were set as follows: mode, assist control; peak flow, 40 L/min; pressure limit, 60 cm H<sub>2</sub>O; tidal volume, 800 ml; rate, 10 cycles/min; sigh pressure limit, 65 cm H<sub>2</sub>O; sigh volume, 1,200 ml; sigh rate, every six minutes, two in sequence; expiration resistance off, nebulizer on. The instrument was tested with one liter of sterile water in the cascade humidifier, where the temperature was set at 37°C. Bacterial suspensions were poured into a sterile updraft nebulizer powered by the ventilator, which was spliced into a sterile disposable intensive care ventilation circuit on the inhalation side, about six inches from the Y-piece. A 500-ml rubber test lung was attached to the patient's port on the Y-piece.

In the first set of experiments, filters were used to trap and allow enumeration of organisms at different sites in the circuitry. Ten-ml suspensions of *Pseudomonas aeruginosa* ATCC 27853 at 1,150,000 colony-forming units (cfu)/ml, and 10 ml of sterile deionized water were alternately placed in an updraft nebulizer for 30-minute periods. Counts were not taken when water was nebulized. This technique of alternating bacterial suspensions and water allows for inoculum washout of the nebulizer and a break in inoculum nebulization.<sup>1</sup> During a 30-minute test period, two of the ten ml inoculum was nebulized.

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Table 1. Quantitation of *P aeruginosa* at Different Circuitry Sites

Site	Time (min)	Organisms/ml of Pellet
Spirometer—inlet port	30	30
Sterile water	60	ND
Water trap—inlet port	90	28
Sterile water	120	ND
Circuit junction	150	9100
Sterile water	180	ND
Spirometer—inlet port (repeat)	210	TMTC

TMTC (too many to count), ND (not done)  
Inoculum was 1,150,000 cfu/ml

The 30-minute period was chosen because it takes about 30 minutes for organisms to traverse the circuitry. When the test organism was being nebulized, filters were in place at the following sites, in this order: (a) inlet port of spirometer (13 ft 8 in from test lung), (b) inlet port of water trap (7 ft 6 in from test lung), (c) inlet port of circuit junction manifold, (3 ft 6 in from test lung), and (d) inlet port of spirometer (repeated).

A 5% sheep blood agar plate was placed at the exit port (d, above) of the spirometer while the filter was in place at the spirometer inlet port. Then the organism suspension was left in the nebulizer, the filter was removed from the spirometer inlet port, and another 5% sheep blood agar plate was placed at the spirometer exit port. Counts were taken on all filters and plates.

In the second set of experiments, filters were placed at the inlet port of the spirometer, and 5% sheep blood agar plates were taped to the exit port to allow for enumeration of organisms and to test filter efficacy. Ten ml of a suspension of the test organism, at 115,000 cfu/ml (lower inoculum concentration than first set of experiments) was placed in the updraft nebulizer. To allow enumeration, a new sterile filter was placed at the inlet port of the spirometer, and a new 5% sheep blood agar plate was attached to the spirometer at the exit port every 30 minutes (no water in between).

Enumeration of organisms from filters was as follows: following the contamination period, filters were removed from the metal filter housing, 25 ml of sterile deionized water were added to the contaminated side of the filter, parafilm was placed over the opening, and the filter was vigorously agitated for one minute. The liquid with organisms was then poured into a sterile test tube. This was repeated with another 25 ml aliquot of sterile water. The 50-ml sample was then centrifuged in plastic centrifuge tubes at a relative centrifugal force (gravities) of 2600, using a Sor-

vall RC-3B centrifuge with an H-6000A swinging bucket rotor. Forty-nine milliliters of supernatant were discarded and the 1-ml pellet used for quantitation.

Sheep blood agar plates (100-mm-diameter) were incubated at 35°C for 24 hours following exposure. Exposure was accomplished by removing the plate lid and taping the bottom portion of the plate so the agar surface was in the path of air leaving the spirometer. Typical colonies of the test organism were then quantitated. This procedure has been previously used.<sup>1</sup>

Two different concentrations of inocula were tested to allow for comparison of inoculum effect. These concentrations were chosen because they approximate and exceed, respectively, those concentrations believed to be significant in vivo during infectious processes.

## Results

Table 1 shows that contamination (3 colonies/ml) was detected at the spirometer after just 30 minutes. Contamination was greatest closer to the nebulizer; however, given enough time (3½ hrs) and with a large enough inoculum concentration (1,150,000 cfu/ml), even the spirometer became grossly contaminated. While the filter was connected to the inlet port of the spirometer (repeat step), many organisms were trapped on the filter, and none were detected on the sheep blood agar plate (which was placed at the exit port of the spirometer) following incubation. However, when the filter was removed, 213 colonies grew on the subsequent agar plate.

Table 2 notes that when a bacterial suspension of 115,000 cfu/ml was nebulized over a period of time,



Figure 1. The Pall BB-50T Bacterial Circuit filter.

Table 2. Filter Efficiency Test at the Spirometer

Time (minutes)	Number of Organisms	
	Filter*	BAP†
30	0	0
60	36	0
90	>100	0
120	>100	0
150	40	1
180	14	1
210	32	0
240 (filter removed‡)	—	35

\*Number of organisms per ml of centrifuge pellet.  
†Number of colonies per agar plate.  
‡The filter was removed after the seventh filter change at 210 minutes.  
BAP (blood agar plate)  
Inoculum was 115,000 cfu/ml.

bacterial counts at the spirometer gradually increased for the first several hours, then decreased. When the last filter was removed (after 210 minutes), with the test organisms still being nebulized, 35 organisms were detected at the spirometer exit port on a blood agar plate. Compiled results from Table 2 also show that the filter was >99% effect in trapping test organisms.

## Discussion

This study was done for two reasons: (1) to quantitate bacterial contamination at different sites in the circuitry of MA-1 volume ventilators and (2) to evaluate the efficacy of a new filter (BB-50T). The BB-50T filter is made of a medium which is hydrophobic, thus repelling water and resisting "wet-block." Resistance to the filter is less than 0.9 cm of H<sub>2</sub>O column pressure at 50 L/min flow (manufacturer's literature). Results of the first set of experiments showed that when an organism was nebulized into the circuitry, bacterial levels were initially highest near the nebulizer and lowest near the spirometer, but eventually the whole circuitry became highly contaminated. Another interesting finding is that it took no longer than 30 minutes for organisms to reach the spirometer inlet port from the nebulizer (Table 1).

The second set of experiments showed the filter to be very (>99%) efficient in trapping organisms. This confirms an earlier study in which the BB-50T

filter was reported to have achieved a 99.999% bacteria removal efficacy.<sup>4</sup> Organisms resulting in the two colonies noted in Table 2 under BAP may have escaped through the system while filters were being changed. Results from this table also note that when the suspension was nebulized over a period of hours, contamination counts at the spirometer seemed to reach a peak, then decline. The reason for this pattern is not clear, but it may be related to the circuitry saturation (with organisms) point, migration, and time.

For quantitation, the BB-50T should be equal to or better than using an agar plate taped to the spirometer port. The filter can also be utilized at different sites throughout the circuitry.

## Conclusion

The use of the BB-50T or other similar filters to prevent the escape of pathogenic bacteria from spirometers of volume ventilators and other aerosol-generating instruments may reduce the spread of infectious agents to patients and hospital personnel.



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# Drug Screening — The Provider's Perspective

MARGARET S. JAFFE

**Medical providers must take an active role in the development of a legal and quality drug surveillance program for the companies they serve. Knowledge of toxicological implications, familiarity with drug screening policies, and confidence in the laboratory performing the tests are vital parts of the provider's role in drug screening.**

**M**any industrial clinics are being asked to offer drug screening today. According to the *Wall Street Journal*, "Drug screening tests, which began in the military and spread to the sports world, are becoming more common in the work place. An estimated 25% of Fortune 500 companies now screen job applicants or current employees for signs that they use illegal drugs, according to the U.S. Drug Enforcement Administration."<sup>1</sup>

This article looks at drug screening from the perspective of the medical provider — the person who collects the urine specimens and ships them to laboratories for testing. What is the provider's responsibility for the accuracy of results? How can the provider ensure proper collection methods? How can he protect the patient, the company, and his or her own practice against claims of false positive results?

## Drug Screening Programs

There are four types of drug screening programs:

1. Pre-employment
2. Random (or indiscriminate drug screening)
3. Accident related
4. Probable cause

The *pre-employment* program is the easiest to institute since the company does not need to deal with incumbent employees. However, to properly and legally perform pre-employment screening requires a coordinated effort between the personnel department, the CEO, safety personnel, union officials (if applicable), the legal department, the medical department (if applicable), and the medical provider.

As a provider, what should you look for in a company's drug screening policy to ensure that your services are of the highest quality *and* legal? Read the company drug policy, searching for the job applicant's notification of the requirement to submit to drug screening. Examine the drug release form, assuring yourself that it is properly worded to include every aspect of the testing procedure and that it is always properly witnessed and signed. Applicants or employees should arrive at your clinic with a release signed and witnessed *by the company*, not by your staff. If the company wants you to have the form signed, be sure there is agreement on what steps are to be taken if the applicant refuses to sign. If the applicant arrives without the form, and you have not customarily completed the forms, send him or her back to the company for the proper paperwork — do not become involved in company policy. If an applicant refuses to sign a release form, *do not* collect urine. Note the

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refusal on the release and ask the individual to sign the form, stating that he has refused the test.

Instruct your staff to answer honestly all *questions* posed by the candidate. If the candidate wants to know what drugs you are testing for, tell him. If the candidate wants to know how long THC will remain in the urine, tell him. If the candidate openly admits to drug use, explain his options, remaining objective.

Some companies have a pre-employment screening program only — that is, they have no policy allowing them to screen incumbent employees. Be sure you know what types of screening are covered in each company's policy before you collect urine.

The *random screen* means that the company has the legal right to randomly choose employees to undergo screening. These tests are usually performed at the work site. However, occasionally employees might be sent to your hospital or clinic for the procedure. Random screens must be handled with care to avoid charges of discrimination.

Often companies require witnessed specimens for random screens. This requires one of your staff members of the same gender as the employee to be present in the collection room. If you agree to conduct this procedure, you must have both male and female staff available at all times. Many times, companies will supply a supervisor to witness collection so that the provider does not have staff tied up. Whichever system you choose, all parties must be in agreement *before* the random screen begins.

## **Random screens must be handled with care to avoid charges of discrimination.**

From the provider's perspective, *accident-related* and *probable-cause* programs are the most difficult to develop. The incidents are spontaneous and often occur at times that require the employee be taken to facilities other than your office. It is important that you coordinate the collection of urine and blood at those facilities.

*Accident-related* and *probable-cause* screenings

usually require *both* urine for drugs and blood for alcohol levels. Be sure that the corporate policy allows the medical provider to draw blood as well as collect urine. If this is not clearly delineated in the release form, you cannot legally release the results to the company.

Once again, release forms and proper instructions for handling samples must have been supplied to the medical provider before results can be legally released. If an employee arrives in the medical provider's emergency room apparently under the influence of drugs or alcohol, with no supervisor accompanying him, and no drug/alcohol screening release form is signed, the medical provider cannot help the company. Working closely with your companies can help educate them about the laws protecting patient confidentiality.

## **Choosing a Laboratory**

Once you are satisfied that the corporate drug and alcohol policy protects the company, the employee, and you, you must choose a laboratory to conduct the screening tests.

Often a company will come to you with its policy, its instructions, *and* a laboratory already selected. However, industry has had a difficult time "shopping" for laboratory support. The problems encountered are numerous. Companies need rapid turn-around time, reasonable prices, and a mandatory chain of custody regimen and toxicologists who understand the company's problems.

Many companies can examine turn-around time and prices on their own. They need you to advise them on the technical aspects. There is a veritable sea of alternatives. Prices can vary from \$185 per test to \$11 per test. Turn-around time can vary from two weeks to two hours. Some laboratory supply companies try to sell equipment to be used by industry in on-site testing. Some national laboratories promise courier services and overnight results. Some hospitals assure companies that there is no need to send samples out of state because they can process their samples in the hospital. Some physicians' offices purchase their own equipment to screen urine.

There is no foolproof method for assuring 100% reliability of results in urine drug screening; urine can be analyzed using any number of methods. Immunoassays, thin-layer chromatography, gas chromatography, high-performance liquid chromatography, and gas chromatography/mass spectrometry (GC/MS) are all used.

None of these methods provides 100% accuracy.

Table. — Confirmation Methods for Drug Screening Tests<sup>3</sup>

Screen Method	Manufacturer's or Lab's Lowest Standard Detection Limit	Suggested Confirmation Method	Detection Limit
Enzyme Immunoassay Syva St	100 ng/ml	TLC	5-20 ng/ml
Enzyme Immunoassay Syva Lab Systems	10 or 100 ng/ml	TLC	5-20 ng/ml
Radio Immunoassay	5-20 ng/ml	TLC	5-20 ng/ml
TLC	5-20 ng/ml	RIO	5-20 ng/ml
TLC	5-20 ng/ml	Syva Lab Sys	20 ng/ml
TLC	5-20 ng/ml	GC/MS	5 ng/ml
RIA	5-20 ng/ml	GC/MS	5 ng/ml
Enzyme Immunoassay Syva St	100 ng/ml	GC/MS	5 ng/ml
Enzyme Immunoassay Syva Lab System	20 or 100 ng/ml	GC/MS	5 ng/ml

Most companies find that *confirming results with an analytical methodology that is totally different from and more sensitive than the screening method* is a necessary part of their programs. Company decision makers must be made to understand the technicalities of drug screening so that they can make educated decisions. Otherwise, they will choose programs for price and convenience rather than accuracy in reporting.

On the other hand, methodology does not need to be so sophisticated that the procedures become unduly cumbersome and expensive. The chain of custody must be devised so that the employee is protected and the results will hold up in court. The technology used must be reliable and reproducible.

The drug screening explosion has occurred partially because of advances made in screening techniques and because of industry's increasing awareness of the drug problem. Cheaper and faster methods are allowing companies to screen their employee population.

As explained in the *Journal of the American Medical Association (JAMA)*, "Immunoassays depend on competitive protein binding and are presumptive tests. They must be confirmed by adequate alternative chemical analyses, if any weight is to be placed on positive findings. The immunoassays are popular because they allow for large-scale screening of many specimens with readily available reagents and instruments, at a reasonable cost, with a minimum of personnel training, and without time-consuming sample preparation." However, the article continues, it is "virtually impossible, in practice, to standardize immunoassays so that results are comparable when urine is analyzed by two different immunoassays or even the same immunoassay using different batches

of antibody. Thus, a single urine specimen can be positive by one immunoassay and negative by another."<sup>2</sup>

It is important to use an analytically different screening method for confirmation because "the scientific community, hence the legal system, does not recognize a sample as being, in fact, positive unless at least two (2) different analytical methods have been employed to identify a substance. If two (2) different analytical methods are not used the question of a 'false positive,' improper and scientifically unacceptable methodology, will be used by the legal system to possibly dismiss a case. This could result in an employer being liable in a monetary situation.

"Remember, the confirmation method used must be as sensitive, preferably more sensitive, than the screening method [Table]. . . Confirmation by GC/MS often involves additional charges; however, this method should be employed if legal action is a possibility. Confirmation by GC/MS is, without question, the most definitive identification of a compound."<sup>3</sup>

The Centers for Disease Control (CDC) in Atlanta have noted, "When the manufacturer's instructions are followed, urine samples containing at least the stated detection level of 9-carboxy-THC will test positive at least 95% of that time. In a CDC-field-test survey of 64 laboratories those using the SYVA (Emit®) system for urine screening of cannabinoids had an incidence of 4% false positive results; whether these errors were analytical or clerical in nature was not determined. The manufacturer states that any positive test should be confirmed by an alternate method."<sup>4</sup>

In court, confirmation by GC/MS will protect the client and the employee's rights. GC/MS is the only method that definitely identifies beyond doubt the

presence of a drug. This methodology gives a fragmentation pattern of each drug that is similar to a fingerprint, ie, each drug can be definitely identified.

When a company is testing employees (random, accident-related, and probable-cause testing) the laboratory must use GC/MS to confirm or results will not hold up in court.

Information concerning laboratories' methods and reliability is not currently available to the medical provider. There is no mandatory national certifying agency for drug analyses even though analyzing blood alcohol for legal purposes usually requires certification. If the laboratory performs clinical services for Medicare or Medicaid patients, the services must meet CDC guidelines. However, if no Medicare or Medicaid work is performed, a laboratory can set up shop without interference from any regulatory agency. Medical providers should check the credentials of the laboratory providing toxicology services to companies and advise those companies of their findings.

Medical providers often have not been properly instructed on collection methods. A laboratory that *certifies* its providers is one that is taking an extra step to protect the integrity of the entire drug screening process.

## **There is no foolproof method for assuring 100% reliability of results in urine drug screening.**

Earlier this year *JAMA* reported, "The College of American Pathologists has a voluntary program that could be used to assess the proficiency of analysts. Evidence should be available that the methods used adequately identify and quantitate the drug when the results are to be used in adversarial proceedings. Most laboratories and personnel offering such analyses are not accustomed to the requirements concerning the handling, examination, and documentation of evidence and findings in such a way that the results will be acceptable for use in legal proceedings.

"Physicians and others should be aware of the problems that may arise when tests are made for abused drugs."<sup>5</sup>

Other problems encountered are:

- Commitment to drug screening — Many clinical laboratories have folded their program into their toxicology departments and have not ensured that the special needs of industry are met.

- Some of the national laboratories are growing at a rapid pace. They are suffering from internal problems which could jeopardize industry's drug screening programs.

- Misunderstanding of the chain of custody needed — Some laboratories give results over the phone to unidentified callers. Reports are mailed to companies without proper procedures to protect confidentiality. Medical providers do not have any control over reporting methods in most cases.

- Setting the limits of positivity — Some laboratories set their lower limits of positive at 100 ng/ml for THC. Others select 50 ng/ml and still others 20 ng/ml. Twenty ng/ml is the lowest rate accepted by the courts as a positive (to exclude passive smoking). Companies must make sure that the level selected by them is being acknowledged by the laboratory so that consistency in reporting is achieved.

### **The Medication History**

Some drugs will cross-react with certain types of testing methods, causing false-positive results. Immunoassays, in particular, lend themselves to cross-reactivity. Thus, obtaining a careful medication history is a standard part of the screening process.

In a recent alert from Syva Laboratories, it was reported that ibuprofen had cross-reacted with the Emit<sup>®</sup> system, causing false-positive results. How many patients are using ibuprofen (Nuprin<sup>®</sup> or Advil<sup>®</sup>) and don't even consider it medicine?

It is not good enough simply to ask the patient if he has taken any medication or drugs lately. Many people do not think of aspirin or over-the-counter cold medication as "medicine." It is important to specifically list different categories of medication. To neglect this step is to leave the company open to future litigation. One of the loopholes of on-site testing is that often untrained people collect the sample. A laboratory or medical provider experienced in drug screening will always include a medication history in the protocols (Fig ).

### **Collecting the Urine**

Companies use many different sources for their occupational health needs. Some use a local emergency room and others use private physicians' offices, while still others might use an occupational health clinic. Regardless of the facility, communication between

the company and the provider must be open in order to develop a drug screening program.

Collection of the urine sample is a step which should be taken with great care. Even if the laboratory used takes great pains in analyzing the specimen, sloppy technique in collecting and labeling the sample can put the provider and company at risk for litigation.

Some companies want all samples witnessed. If this is agreeable to you, then you must develop protocols to do so. Other companies will allow unwitnessed samples but a clear understanding of collection methods must be agreed upon by each party involved.

As urine drug screening has become more widely employed, the general public has become more sophisticated in evading or invalidating the tests. The following are a few hints to improve your collection methods. Remember, *drug screening programs are not meant to be used as legal weapons to uncover illicit drug users*. Rather, they are an attempt to provide a safe and drug-free work place. For this reason, it is not necessary to play detective and police officer. Proper collection, labeling, and mailing will provide a company with a drug screening program that meets its goal of assuring a safe work place.

The office staff should first understand the purpose of the program, its goals, and its objectives, and should be given a clear description of the possible legal repercussions.

Collection of specimens for drug screens is very different from collection for diagnostic testing. Proper *witnessed labeling* is of utmost importance. It is also necessary to protect the specimen from intentional contamination by the patient who tries to prevent detection of drugs of abuse.

The staff member should ask that the employee

**A single  
urine specimen can be  
positive by  
one immunoassay and  
negative by another.**

or applicant bring the urine specimen to him or her (in the case of an unwitnessed collection). Do not leave the sample in the bathroom. When it is handed to the staff member, the employee should watch the bottle being sealed and should sign and date the

**Figure 1.** — Medication History Used by Industrial Health Management Services, HCA — Oklahoma City Division

Check which of the following, if any, you have taken in the last two weeks:

Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	Allergy medicine
<input type="checkbox"/>	<input type="checkbox"/>	Asthma or wheezing medicine
<input type="checkbox"/>	<input type="checkbox"/>	Cold medicine
<input type="checkbox"/>	<input type="checkbox"/>	Cough medicine
<input type="checkbox"/>	<input type="checkbox"/>	Depression medicine
<input type="checkbox"/>	<input type="checkbox"/>	Diet pills
<input type="checkbox"/>	<input type="checkbox"/>	Laxatives
<input type="checkbox"/>	<input type="checkbox"/>	Mood elevators
<input type="checkbox"/>	<input type="checkbox"/>	Muscle relaxers
<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, or diarrhea medicine
<input type="checkbox"/>	<input type="checkbox"/>	Pain medicine
<input type="checkbox"/>	<input type="checkbox"/>	Seizure medicine
<input type="checkbox"/>	<input type="checkbox"/>	Sinus medicine
<input type="checkbox"/>	<input type="checkbox"/>	Sleeping pills
<input type="checkbox"/>	<input type="checkbox"/>	Stomach, colon, or digestive medicine
<input type="checkbox"/>	<input type="checkbox"/>	Tranquilizers ("Nerve Medicine")
<input type="checkbox"/>	<input type="checkbox"/>	Heart medicine

Please list other drugs or injections. (Please include non-prescription)

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evidence tape or whatever packaging mechanism is provided by the laboratory. Allow the employee to check the forms to ensure that demographic data is correct.

If the employee or applicant is to give an unwitnessed specimen, request that all personal belongings be left outside the bathroom. If possible, collect the specimen when the employee is in an examining gown rather than street clothes.

When the specimen is handed to the medical professional, its temperature should be noted. If the specimen is unusually cold or warm, make a note on the laboratory slip, alerting the laboratory that the sample might contain tap water or be "foreign" urine (stashed earlier or carried into the collection room).

Some clinics actually turn off the water in the bathroom to prevent dilution or tampering or collect in a "dry" collection room with no running water.

Note the color of the urine. If it is very clear, some labs or clinics will dipstick it to check specific gravity. If the specific gravity is less than 1.001, note this on

the lab slip. It is wise to check with your laboratory about suspect urines. Some laboratories will provide methods to flag those urines that are suspect. They can check such samples for BUN or creatinine before they begin to screen for drugs.

Check the collection room before and after each submission of urine. Bottles containing "clean" urine can be hidden under or in garbage cans, in the toilet tank, or elsewhere.

In the case of probable-cause testing, it is wise to have a company representative or medical professional of the same gender witness the collection process. Chain of custody in this case must be immaculate.

Any number of specimen bottle sizes may be supplied by the laboratory. If the bottle has a narrow opening, the employee (especially a woman) could have difficulty voiding into it. You can supply her with a wide-mouthed plastic specimen cup and transfer the contents, but it is imperative that she witness the transfer and sign the evidence tape. Be sure to dispose of the original specimen cup. Do not reuse sample cups. Allow the employee to inspect the supplied bottle before transfer.

Specimens should be mailed or shipped as soon as possible. If there is any delay, they may be kept in a cool, dark, safe place until the following day. Increased temperature may cause some degradation of drugs in urine.

## The Future from the Provider's Perspective

The business community's embrace of urine drug screening is seated in complex reasons. The Los Angeles Times points out, "The prevalence of drugs among the working population has left industry no alternative than to confront the problem. It is not

unusual for a company to experience a 30% positive rate when they institute their programs and some figures are as high as 45%."<sup>6</sup> Those screenings are rather like spanking your children — you do it because you can't think of anything else to do.

The medical community can't hide from the issue either. Drug screening programs must have representation from the medical community. Laboratories should be forced to use adequate techniques which mandate confirmatory tests on all positives and should also undergo periodic testing by outside technicians.

Blind testing methods and laboratory certification should be developed by a professional organization to ensure protection for the companies, the employees, and the medical providers. □

*The JOURNAL assumes no responsibility for the opinions expressed in this article. To assure the legality of any drug screening program, obtain legal counsel.*

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*Margaret S. Jaffe, PA-C, is vice president of Partners in Health (Hospital Corporation of America), director of Industrial Health Management Services, and director of the Presbyterian Hospital Emergency Department, Oklahoma City. She completed her physician assistant program in 1977 at the University of Oklahoma College of Medicine.*

## Trypsin in Hyaline Membrane Disease

J. WILLIAM FINCH, MD

**For years, hyaline membrane disease has been frequently fatal to newborn babies. It can be quickly and cheaply relieved in twelve to twenty-four hours using trypsin administered by injection or orally.**

In 1965 I published in *Medical Times* my results with treating hyaline membrane disease with trypsin. At that time I had only treated three infants, all of whom had severe hyaline membrane disease and whom I fear would have died had not treatment been successful. My treatment was administration of trypsin in  $\frac{1}{4}$  cc doses (3125 units — 1.25 mg) every six hours. The injections were given slowly and deeply intragluteally. The sites of injections were rotated. No local reaction was experienced in any of the three cases. One of the babies was premature and two were full term. All three babies were markedly improved within twelve hours and were apparently cured after forty-eight hours. The only other treatment was incubator care and a small amount of oxygen the first day.

I felt that the results on those three patients, although the series was small, was sufficiently important to publish my findings, hoping to encourage others to try this treatment. It is a simple and inexpensive treatment of a disease heretofore rapidly fatal in about 90% of the babies afflicted.

Just about the time this was published and sent to all of the area doctors, the International Drug Company of Philadelphia ceased making any injectable trypsin, saying that it was too expensive to market and leaving only trypsin tablets on the market. I purchased all of the trypsin available in this and surrounding states, as well as some from Old Mexico, and treated thirty-four cases of hyaline membrane disease. In every case the patient was markedly improved within twelve hours and was apparently cured within twenty-four to forty-eight hours.

After injectable trypsin was removed from the market, I treated a total of thirty-four cases over a

**In every case  
the patient was  
markedly improved within  
twelve hours.**

period of fifteen to eighteen years. All of the patients responded the same as the first three, and all are still living.

Two or three years ago one of my female preceptees (I having been preceptor for about forty years) saw another doctor's patient with definite hyaline

J. William Finch, MD, FACP, The Hobart Clinic, 101 South Broadway, PO Box 591, Hobart, OK 73651.

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membrane disease. With that physician's permission and mine, she treated this child with trypsin tablets. She ground the tablet very, very thoroughly and gave the baby  $\frac{1}{4}$  of it on his tongue every six hours. Surprisingly, this baby recovered just about as fast as those treated with injectable trypsin. This treatment has been used twice since, with success both times. Apparently trypsin, either in powder form given orally or injectable form as was used back in 1964, will still work and is still the treatment of choice for hyaline membrane disease.

I have written several companies, thinking that under the Orphan Drug Act they might start making injectable trypsin for me, but they all reported that it is too expensive to produce. They suggested continued use of the tablets.

Trypsin has been found to be very useful in inflammatory and edematous processes where fibrin micro-molecules are trapped in the walls of the capillaries

and in the connective tissues. These fibrin deposits block the free flow of body fluids and impede the resolution of inflammation and the reabsorption of edema fluid. Following the administration of trypsin, these fibrin molecules are decreased in size by enzymatic action; thus, the free flow of blood and other body fluids is restored, and the tissue repair is accelerated.

Having delivered 4,095 babies in private practice, I am very interested in getting trypsin reestablished as treatment for hyaline membrane disease. It is certainly completely without harm, very inexpensive and, in my experience has worked 100% of the time. **J**

*J. William Finch, MD, FACP, is a clinical associate professor of medicine at the University of Oklahoma. He was graduated from the university in 1931, specializing in internal medicine. He is a charter member of the Oklahoma Medical Research Foundation and a Life Member of the Oklahoma State Medical Association.*

## Coming in November . . .

November is the scheduled publication date for the JOURNAL's next "Leaders in Medicine" article. Manuscripts being considered for publication include a paper on recombinant DNA and a report on long-term mechanical ventilation of patients in an acute care hospital.



## News from the Oklahoma State Department of Health

### Healthy Older People


As the older population increases, there is a need to foster self-responsibility and self-determination. A statewide health promotion coalition targets Oklahoma's older population in effort to bring about life-style changes for staying healthy, or preventing future complications for those who already have a chronic disease.

"Fit for a Better Life — Healthy Older Oklahoman" is the theme for the Coalition of Healthy Older People. The coalition was begun in 1985 after Governor George Nigh designated the Oklahoma State Department of Health as the lead agency to coordinate resource efforts between the Department of Human Services' Special Unit on Aging, Oklahoma Health Advocates of the American Association of Retired Persons, the Red Cross, and other voluntary health agencies and private industry. Drawing upon the agencies' varied health promotion activities, the coalition is hoping to gain the interest and energy of older Oklahomans to bring about life-style changes

that enhance the quality of life and preserve independence.

Health promotion topics focus on the areas of injury control, safe medications management, better nutrition, and improved physical fitness. Other areas of interest include high blood pressure management, osteoporosis, and colorectal cancer.

To assist community health planners, a health promotion source manual has been developed. The source manual outlines program planning, wellness in aging, and media hints, and provides curriculum guides for nutrition, safety, physical fitness, community resources, medication management, and common health concerns. The manual is indicative of the cooperative effort needed in realizing the energy and synergy of the network for the aging.

Physicians interested in obtaining a copy of the manual, or in other health promotion efforts for the older population, may call the Chronic Disease Section of the Home Health Care and Eldercare Division, Oklahoma State Department of Health, (405) 271-4072. 

DISEASE	July 1986	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	2	6	9	9
CAMPYLOBACTER INFECTIONS	28	161	189	—
ENCEPHALITIS, INFECTIOUS	4	14	21	18
GIARDIA INFECTIONS	21	105	151	—
GONORRHEA (Use ODH Form 22B)	1167	7355	7196	8240
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	17	140	135	—
HEPATITIS A	27	192	292	283
HEPATITIS B	24	108	129	147
HEPATITIS, NON-A NON-B	8	37	46	—
HEPATITIS UNSPECIFIED	4	30	50	95
MEASLES (RUBEOLA)	24	36	1	3
MENINGITIS, ASEPTIC	17	46	69	84
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	4	41	49	38
MENINGOCOCCAL INFECTIONS	2	18	21	24
PERTUSSIS	13	69	114	91
RABIES (Animal)	1	39	66	100
ROCKY MOUNTAIN				
SPOTTED FEVER	32	60	72	96
RUBELLA	0	0	1	1
SALMONELLA INFECTIONS	65	249	196	217
SHIGELLA INFECTIONS	37	109	132	152
SYPHILIS (Use ODH Form 22B)	11	96	112	117
TETANUS	1	1	1	0
TUBERCULOSIS	27	150	153	172
TULAREMIA	1	6	12	16
TYPHOID FEVER	0	1	0	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	24
BRUCELLOSIS	0
LEGIONNAIRES DISEASE	10
MALARIA	8
REYE SYNDROME	3
TOXIC SHOCK SYNDROME	17

# THE WIN/WIN ARRANGEMENT FOR PHYSICIANS

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**Simplified Accounting:** You write us one check per pay period, make one journal entry and deduct the entire amount of that check from your taxes.

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# General Election 1986

**A**ssociations have the right to participate in the American political process, and it is their responsibility to exercise this right. When an association forms a political action committee, such as OMPAC, or the association's members choose to involve themselves in the political process, they are participating in the great American tradition of helping to select the most qualified men and women to assume leadership positions in this country.

Below is a listing of general election races involving OMPAC support. Candidates supported by OMPAC are in **boldface**.

Please note that the deadline for this article was in September, prior to the September 16th run-off election. Therefore, it is possible that some candidates *not listed* may now be supported by OMPAC. For a complete list of candidates supported by OMPAC in the General Election, please refer to your October OSMA Newsletter. The general election will be held Tuesday, November 4, 1986.

Thank you for your involvement and support in this year's elections. If you have any questions or comments, please do not hesitate to contact Larry L. Long, MD, OMPAC Chairman, or Robert W. Baker III, OMPAC Director at 1-800-522-9452 or (405) 843-9571.

## Oklahoma State Senate

### District #4

**Larry Dickerson** (D) Poteau, OK

Strong Demo district/Sen. Johnson withdrew.  
Richard Strong (R) Spiro, OK

### District #6

**Sen. Roy Boatner** (D) Calera, OK

Supportive of health issues/tort reform. Member of Human Resources Committee.

James Braly, (R) Durant, OK

### District #11

**Maxine Horner** (D) Tulsa, OK

Favorable recommendation from Cong. Jones and Oklahoma Against Lawsuit Abuse representation.

Carlos J. Chappelle (R) Tulsa, OK

### District #16

**Sen. Lee Cate** (D) Norman, OK

Chairman of Appropriations Committee. Member of Judiciary Committee.

Gary Gardenhire (R) Norman, OK

### District #22

Robert L. Crout (D) Mustang, OK

**Sen. Ralph "Butch" Choate** (R) Hennessey, OK

Supportive of tort reform/health issues.

### District #36

**Sen. Frank Rhodes** (R) Catoosa, OK

Sympathetic to medical issues/tort reform. Member of Human Resources Committee.

James Hogue (D) Tulsa, OK

### District #38

**Robert M. Kerr** (D) Altus, OK

Strong physician support.

Kenneth Schimmer (R) Custer, OK

### District #40

**Sen. Mike Combs** (D) Bethany, OK

**Leo Kingston** (R) Oklahoma City, OK

Physician supported opposition to Sen. Combs.

## Election 1986 (continued)

### District #42

Carolyn Burkes (R) Midwest City, OK

**Dave Herbert** (D) Midwest City, OK

Strong physician support Pro tort reform.

### District #46

Sen. Bernest Cain (D) Oklahoma City, OK

**Tom Hill** (R) Oklahoma City, OK

Physician support. Opponent is pro mandatory assignment.

### District #52

J. Mike Lawter (D) Oklahoma City, OK

**Howard H. Hendrick** (R) Bethany, OK

Physician support/pro tort reform. Opponent is pro chiropractic issues and against tort reform.

## Oklahoma House of Representatives

### District #3

**Rep. James Hamilton** (D) Poteau, OK

Author of tort reform. Member of Select Committee on Insurance Rates and Tort Claims.

Regna Lee Wood (R) Spiro, OK

### District #8

Larry Rice (D) Pryor, OK

**Rep. J. D. Whorton** (R) Pryor, OK

Supportive of tort reform/health issues. Member of Human Resources Committee.

### District #19

**Rep. Gary Sherrer** (D) Snow, OK

Supportive of health issues/tort reform. Member of Professions & Occupations Comm.

Clint Davis (R) Hugo, OK

### District #23

**Rep. Kevin Easley** (D) Tulsa, OK

Candidate for the future. Supportive of tort reform/good relationship with OSMA.

Sue Tibbs (R) Tulsa, OK

### District #25

**Rep. Lonnie Abbott** (D) Ada, OK

Member of leadership team. Supportive of tort reform/health issues. Long-time supporter of OSMA.

Roger Thorpe (R) Ada, OK

### District #27

**Rep. Steve Lewis** (D) Shawnee, OK

Chairman of Appropriations Committee. Supportive of health issues/tort reform. Member of Human Resources Committee.

Carl Franklin (I) Shawnee, OK

### District #32

**Rep. Charlie O. Morgan** (D) Prague, OK

Supportive of tort reform/health issues. Member of Insurance Committee.

Patsy Alsobrook (R) Wellston, OK

### District #33

**Rep. Mike Morris** (R) Cushing, OK

Supportive of tort reform. Easy to work with.

Calvin McIntyre (D) Cushing, OK

### District #35

**Rep. Larry Ferguson** (R) Cleveland, OK

Very supportive of tort reform.

Cam Favaro (D) Terlton, OK

### District #36

**Rep. Don Anderson** (D) Tulsa, OK

Supportive of health issues. Easy to work with. Vice Chairman of Human Services Committee.

John Handsby (R) Skiatook, OK

### District #39

**Lenard Briscoe** (D) Kingfisher, OK

Strong physician support.

Rep. Steven E. Boeckman (R) Dover, OK

### District #41

Dean B. Brown (D) Kremlin, OK

**Rep. John McMillen** (R) Enid, OK

Supportive of tort reform/former hospital administrator. Member of Human Services Committee and Professions and Occupations Committee.

### District #43

**Rep. Harold Hale** (D) El Reno, OK

Supportive of health issues.

Bill Jeffrey (R) El Reno, OK

### District #44

**Rep. Carolyn Thompson** (D) Norman, OK

Supportive of health issues/involved in Physician Manpower Study. Member of Mental Health Committee.

Michael E. Moore (R) Norman, OK

### District #45

**Rep. Cal Hobson** (D) Lexington, OK

Generally supportive of health issues/open door to OSMA.

Richard Gallant (R) Norman, OK

### District #46

Vickie White (D) Norman, OK

**Rep. Joe Cunningham** (R) Norman, OK

Supportive of health issues/tort reform. Member of Human Services Committee and Mental Health Committee.

### District #50

P. O. Kidd (D) Duncan, OK

**Ed Apple** (R) Duncan, OK

Strong physician support.

### District #54

Keith R. Treadway (D) Oklahoma City, OK

**Rep. Ken McKenna** (R) Oklahoma City, OK

Appreciative of medicine's views.

### District #58

Roscoe Hill (D) - Woodward, OK

**Rep. Lewis M. Kamas** (R) Freedom, OK

Strong physician support.

#### **District #66**

**Rep. M. David Riggs** (D) Sand Springs, OK  
Strong leadership abilities. Supportive of most medical issues. Member of Judiciary Committee.  
Lee Everett (R) Tulsa, OK

#### **District #68**

**Rep. Jay Logan** (D) Tulsa, OK  
Supportive of health issues/tort reform. Member of Human Services Committee.  
E. J. Jerry Strout (R) Sand Springs, OK

#### **District #70**

**Rep. Penny Williams** (D) Tulsa, OK  
Strong physician support. Very supportive of health issues.  
Larry W. Self (R) Tulsa, OK

#### **District #72**

**Rep. Don McCorkell, Jr.** (D) Tulsa, OK  
Supportive of health issues.  
Dwight Williamson (R) Tulsa, OK

#### **District #75**

**Rep. Larry J. Schroeder** (D) Owasso, OK  
Supportive of health issues.  
Grover Campbell (R) Owasso, OK

#### **District #78**

Larry Cowan (D) Tulsa, OK  
**Rep. Frank Pitezal** (R) Tulsa, OK  
Physician support/pro health issues.

#### **District #80**

Fred Dorrell (D) Broken Arrow, OK  
**Rep. Joe Gordon** (R) Broken Arrow, OK  
Easy to work with/supportive of health issues.

#### **District #81**

Joe Park (D) Edmond, OK  
**Rep. Gaylon Stacy** (R) Edmond, OK  
Always supportive of medicine/knowledgeable of health issues. Member of Human Services Committee and Insurance Committee.

#### **District #83**

John Williams (D) Oklahoma City, OK  
**Rep. Joe Heaton** (R) Oklahoma City, OK  
Outspoken supporter of tort reform. Targeted for defeat by trial attorneys. Member of Judiciary Committee.

#### **District #84**

Vernon Askew (D) Oklahoma City, OK  
**John Bumpus** (R) Bethany, OK  
Medical doctor. Need we say more!

#### **District #85**

Michael J. Harkey (D) Oklahoma City, OK  
**Rep. Mike Hunter** (R) Oklahoma City, OK  
Targeted for defeat by trial attorneys. Member of Judiciary Committee. Outspoken supporter of tort reform.

#### **District #90**

Bruce Thompson (D) Oklahoma City, OK  
**Charles Key** (R) Oklahoma City, OK  
Insurance business. Known personally. Opponent is employed by Mike Lawter.

#### **District #95**

**Rep. David Craighead** (D) Midwest City, OK  
Supportive of health issues/tort reform.  
J. Robert Blackburn (R) Midwest City, OK

#### **District #97**

**Rep. Kevin Cox** (D) Oklahoma City, OK  
Supportive of tort reform. Targeted for defeat by trial attorneys. Chairman of Insurance Committee. Member of Human Services Committee and Public Health Committee.  
Corlandus Lang, Jr. (R) Oklahoma City, OK

#### **District #99**

**Rep. Freddy Williams** (D) Oklahoma City, OK  
Supportive of tort reform/health issues. Member of Human Services Committee and Public Health Committee.  
Dortha Belser (R) Oklahoma City, OK

### **Governor**

**David Walters** (D) Oklahoma City, OK  
Strong physician support.

**Henry Bellmon** (R) Redrock, OK  
Strong physician support.

### **Attorney General**

Robert Henry (D) Shawnee, OK

**Brian Griffin** (R) Oklahoma City, OK  
Bill Graves publicly endorsed primary opponent of John Bumpus, MD.

### **US Senate**

**Senator Don Nickles** (R) Ponca City, OK  
Physician support/co-author of Federal Tort Reform.

**Cong. James Jones** (D) Tulsa, OK  
Fought mandatory assignment. Opposed physician fee freeze/physician support.

### **US Congress**

#### **Cong. District #1**

**James Inhofe** (R) Tulsa, OK  
Physician support/opponent is an attorney. Good rapport with OSMa.  
Gary Allison (D) Tulsa, OK

#### **Cong. District #2**

**Cong. Mike Synar** (D) Muskogee, OK  
Author of ban on tobacco advertising/physician support has gained greater access to the Congressman.  
Gary K. Rice (R) Catoosa, OK

#### **Cong. District #3**

**Cong. Wes Watkins** (D) Ada, OK  
Strong physician support. Always willing to work with OSMa.  
Patrick K. Miller (R) Snow, OK

(continued)

## Election 1986 (continued)

### Cong. District #4

**Cong. Dave McCurdy (D) Norman, OK**

Strong physician support. Always willing to work with OSMA.

Larry Humphreys (R) Velma, OK

### Cong. District #5

**Cong. Mickey Edwards (R) Oklahoma City, OK**

Strong physician support. Always willing to work with OSMA.

Donna Compton (D) Oklahoma City, OK

## MULTISPECIALTY GROUP NEEDS FOLLOWING PHYSICIANS

Dermatologist, Otolaryngologist, Orthopedist, OB/GYN, Family Practice, and Internist/Oncologist. 30-physician multispecialty group with ambulatory surgery center. Inquiries confidential.

Contact Jim Freed, MD, or Jeanie Bledsoe, Recruiting Coordinator, Southern Plains Medical Center, 2222 Iowa, Chickasha, OK 73018, or phone 405-224-4853.

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*Solid patient satisfaction reported***Study advocates using HMOs for training of medical students**

Health Maintenance Organizations (HMOs) may be increasingly used for on-site training of medical students, according to a study of the costs and benefits of such training. The study notes that patients, nurses, and other physicians report positive impact on quality of care when medical students are trained on-site.

Howard L. Kirz, MD, MBA, Department of Medical Staff Management, and Cheryl Larsen, Department of Medical Education, Group Health Cooperative of Puget Sound, Seattle, found high patient satisfaction when medical students were trained at the HMO they used. Patients in the study were afforded a clear choice to participate in the project. "In this analysis the positive impact (91%) was thought to be more total time with patients and more thorough information provided to patients. Ninety-four percent of the positive answers alluded to one or both of these areas," the researchers report.

The study, published in the *Journal of the American Medical Association (JAMA)*, provides a specific methodology for determining cost for training medical students in a prepaid health care system. Using this methodology, a prepaid system can evaluate the feasibility of new medical student training programs for the HMO site. The researchers also review relationships between the academic medical center and the staff model HMO.

In a related article, Stewart W. Shankel, MD, of the Department of Medicine, University of Nevada School of Medicine and Reno Veterans Administra-

tion Medical Center, and Ernest L. Mazzaferri, MD, Department of Medicine, Ohio State University College of Medicine, Columbus, report on a study that evaluates the importance of "teaching rounds." Believing that "rounds in a teaching hospital should always be teaching rounds," the authors suggest completely eliminating the term "teaching rounds." They see important aspects of teaching occurring on an informal basis among students, residents, and attending physicians. Rounds, they conclude, are a powerful teaching tool.

A commentary by Michael S. Jellinek, MD, Child Psychiatry, Children's and Psychiatry Services, Massachusetts General Hospital, and the Departments of Pediatrics and Psychiatry, Harvard Medical School, Boston, states, "A well-functioning house staff team is essential to inpatient care and teaching." He cites the importance of addressing what he calls "current and potentially rising levels of stress, discord, and dysfunction" in their incipient stages.

Commenting editorially on these articles, J. Willis Hurst, MD, Emory University School of Medicine, Atlanta, says, "The objective of any educational system is to encourage those who are participating in the effort to learn how to learn and to be sensitive to interpersonal relationships." He sees a standard of excellence as the one important element of any teaching program. "The best of teaching systems," according to Hurst, "encourage thinking, discussion, and action by trainees." □



A



B



C



D



E



Unusually cool fall-like weather graced the Fifth Annual OSMA Student Picnic, held August 27 on the grounds at OSMA headquarters in Oklahoma City.

Medical students, spouses, children, physicians, and OSMA staff members were on hand for the event, which featured hamburgers, hot dogs, beans, potato salad, relishes, and dessert. Tables and chairs were arranged on the front lawn, and at times virtually every seat was filled.

The popular event is part of the OSMA's continuing effort to improve communication and understanding between medical students and organized medicine.

*A. Cindy Alsup, OKC, student representative to the OSMA House of Delegates, talks with Lloyd Biby, OKC, chairman of the OSMA Student Section.*

*B. Sharing a table are Dick Heigle, Edmond; Kevin Staveley-O'Carroll, OKC; and John Clark, Edmond.*

*C. Bradly Keller, OKC; Scott Hooker, Stillwater; and Cynthia Landrith, OKC, enjoy their meal.*

*D. Paul Bierig, Stillwater (right), watches as Jeff Reed, Newcastle, and Kirk Stiles, Edmond, pose for their "party pic."*

*E. Pamela Pierson, OKC (sunglasses), delegate to the AMA Medical Student Section, typifies the prevailing mood.*

*Sylvia J. Wingo, Miami, Okla, and Linda Truitt, Moore, struggle to "catch the wave" at the Coke machine.*





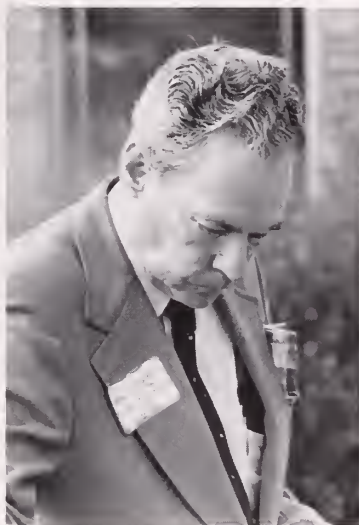
86!

*F. As smoke from the grill billows before him, Mike McKinnon, Bethany, makes his way through the serving line.*



F

*G. OSMA Vice-President Ray V. McIntyre, MD, Kingfisher, was one of several physicians in attendance.*



G

*Mason Lawrence, OKC, gets detailed instructions from his son, David, about what to put on his plate.*



H



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### Highly effective Heptavax-B is safe

## **Hepatitis B vaccine does not contain or transmit AIDS virus**

The vaccine developed to protect health workers and others from hepatitis B infection is safe and carries no threat of AIDS, according to a recent report.

Donald P. Francis, MD, of the Centers for Disease Control, Atlanta, and colleagues tested the safety of Heptavax-B, the only vaccine licensed in the United States for prevention of hepatitis B infection. Even though the vaccine has been shown to be highly effective, some persons at risk have been reluctant to be immunized, the researchers say, because they thought the vaccine might carry some risk of AIDS. (Persons at risk for acquiring AIDS, especially homosexual men, are known to have donated plasma used to manufacture the hepatitis B vaccine).

"The laboratory data presented herein support the claim that the plasma-derived hepatitis B vaccine licensed in the United States neither contains nor transmits the AIDS virus," the researchers say in the *Journal of the American Medical Association (JAMA)*. They found that each of the three inactiva-

tion steps (pepsin at pH 2, 8M urea, or 0.01% formaldehyde) used in the manufacture of the vaccine independently will inactivate the infectivity of the AIDS virus. Further, the researchers report that the vaccine does not contain detectable levels of nucleic acids related to the AIDS virus, and that recipients of the vaccine do not develop antibodies to the AIDS virus.

"Notwithstanding the experimental work described in this and other communications, the real evidence of the safety of any vaccine comes from its clinical record in humans," the researchers observe. Approximately one million Americans have received the vaccine, many of them several years ago, yet none has developed AIDS except those belonging to known risk groups. It is likely that any such cases of AIDS would be reported, the researchers add, since most recipients of the vaccine have been health care workers, and the potential for nosocomial transmission of the AIDS virus has been closely monitored. □

### High rate of false positives

## **AMA discourages corporate use of polygraph as employee screen**

Although polygraph or "lie-detector" tests provide valid sources of information in criminal investigations, their use in personnel screening should be discouraged pending further study, according to the AMA Council on Scientific Affairs.

"The effect of polygraph testing to deter theft and fraud associated with employment has never been measured, nor has its impact on employee morale and productivity been determined," notes the Council's report.

The few studies that have been performed show no greater accuracy for such tests than for the control-question testing used in criminal cases. In criminal cases, a classification of guilty can be made with 75% to 97% accuracy, the report notes, but the rate of false positives is high enough to require other sources of evidence.

"It has been estimated that, even if the results of the polygraph testing were 95% valid and the predictive value was 50%, in a screened population of 1,000 in which 5% were guilty of some transgression, 47

of the 50 guilty people would be apprehended but 47 innocent people would also be labeled as guilty," according to the report.

Even these estimates may be too optimistic, since they are based on criminal investigations. The physiological arousal of the sympathetic nervous system might be less drastic among guilty employees; conversely, since most of those questioned would be innocent but potentially frightened by the test, the number of false positives may be greater.

"The erosion of employee morale and the risk of employer liability may not be worth the possible benefits of uncovering a disloyal employee," the report concludes.

Factors that might influence reliability of test results include operator training and experience, test setting, subject psychopathy, intelligence, autonomic response, physical activity (tensing of muscles), drug use, and attitudes about the test. The council believes these and other factors require further study before polygraph testing is used by employers. □

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Relapses delayed, survival rates increased

## Report confirms value of drugs in fight against breast cancer

A new statistical analysis concludes that adjuvant chemotherapy for operable breast cancer — especially stronger, multidrug treatments — can delay relapse and boost survival rates.

The study, conducted at the Harvard School of Public Health by Harvey N. Himel, MD, and colleagues, was designed to address an ongoing debate over whether adjuvant chemotherapy — the post-surgical use of anticancer drugs — improves the overall health and increases the life expectancy of patients with primary breast cancer.

“Traditional reviews of the literature have tended to promote the use of chemotherapy, although there have been some dissenters,” the report says. “These reviews, however thorough, derive conclusions from qualitative reviews of the various studies’ results and the disparate conclusions of the individual investigators.”

The new study, appearing in the *Journal of the American Medical Association (JAMA)*, examined reports published over the past 30 years on 28 randomized control trials of 12 anticancer drugs used alone or in combination. Nearly 10,000 patients were enrolled in these trials.

Of these studies, nine reported on long-term trials (minimum two-year follow-up) comparing patients receiving chemotherapy with untreated control subjects.

Data from these trials, dating to 1969 and involving 2,954 patients, were pooled to calculate estimates of relapse-free survival rates and overall survival rates. The analysis found chemotherapy improved relapse-free survival rates by 11% three years after treatment and by 8% after five years, with studies using multiple agents showing a greater effect.

Overall survival rates at three years also improved, but only for studies involving multiple agents, the researchers reported. Combining data for other types of trials yielded inconclusive results, they said.

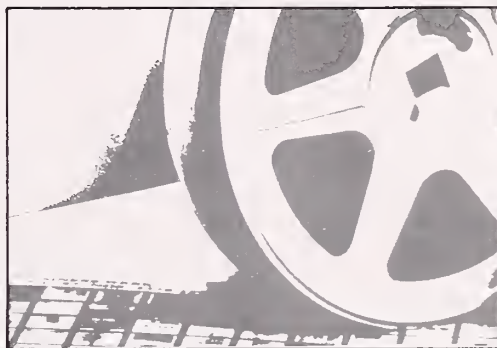
“The combined data suggest that the less toxic single-drug regimens delay relapse in a small percentage of patients, but do not influence overall survival,” the study reports. “However, the more toxic multiple-drug regimens postpone relapse for a larger percentage of patients and improve overall survival, especially in certain subgroups.”

The researchers caution, however, that better data must be gathered over longer periods of time “to be confident about the place of chemotherapy for all groups of patients.”

The report also notes “wide variation in the quality of the research design and execution and grave deficiencies in the reporting of essential clinical data” among the studies reviewed. This allowed the researchers to use only about half the potentially available information.

The researchers say they noted these problems in an effort to “stimulate an improvement in the publication standards for medical reporting.”

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## Freezing pork reportedly kills cysticerci, or tapeworm larvae

Cysticerci, or tapeworm larvae, may be effectively destroyed in pork by simply freezing the meat for a few days before consuming it, according to a report in the *Journal of the American Medical Association (JAMA)*.

Julio Sotelo, MD, and colleagues, of the Instituto Nacional de Neurologia y Neurocirugia, Mexico City, compared the survival rates of cysticerci of *Taenia solium* from pork exposed to different temperatures for various periods. "Refrigeration of pork muscle infested with cysticerci at temperatures above 0°C did not affect the parasites' survival in culture," the researchers say. "Conversely, freezing of meat prevented survival of cysts."

Cysticerci were killed when pork muscle was stored for four days at -5°C, three days at -15°C, or one day at -24°C. The researchers conclude that freezing meat at these temperatures would help prevent the most frequent parasitosis of the human central nervous system. Parasitic diseases are endemic in developing countries, where preventive measures are least likely to be followed.

"Even when the life cycle of most parasites is well known, preventive measures are difficult to implement because of educational, economic, nutritional, and cultural factors that pose obstacles," the researchers observe. However, the sequelae and disability induced by neurocysticercosis require that its prevention become a major goal of modern medicine, they say.

"The most important guidelines for prevention of cysticercosis are treatment of *T. solium* carriers, hygienic handling of food, intensive washing of vegetables, thorough cooking of pork, and proper disposal of feces," the researchers note; yet, all of these measures have proved difficult to accomplish in developing countries. Simple methods for prevention that can be overseen by public health departments and enforced by law may be the most practical, they conclude. In countries where cysticercosis is endemic, pork should be frozen at the proper temperature before distribution to butchers. □

### *Study done in Kansas*

## Herbicides put farmers at risk for non-Hodgkin's lymphoma

A study of Kansas farm workers indicates that agricultural exposure to herbicide boosts the odds of developing non-Hodgkin's lymphoma — a risk that increases significantly with intensity of exposure.

The population-based, case-control study, conducted by Sheila K. Hoar, ScD, of the National Cancer Institute's Epidemiology and Biostatistics Program, and colleagues, confirms earlier reports by Swedish researchers and others linking NHL to agricultural herbicide use. The new study does not, however, confirm other earlier research linking herbicide exposure to two other types of cancer: Hodgkin's disease and soft-tissue sarcoma.

Kansas, a major wheat-producing state, was chosen for the study because herbicides have been used on wheat more frequently than other chemicals. Kansas also has a statewide cancer reporting system.

The study involved telephone interviews with 424 men newly diagnosed between 1976 and 1982 with soft-tissue sarcoma (STS), Hodgkin's disease (HD), or non-Hodgkin's lymphoma (NHL), and 948 male

control subjects drawn from the general Kansas population.

Interviewers gauged agricultural herbicide exposure in both groups, and the study controlled for such variables as exposure to other agricultural chemicals, nonfarm exposure, and both known and alleged risk factors for the three cancers.

The researchers found no consistent pattern of excess risk of STS or HD associated with either the duration or frequency of herbicide use, and no significant risk of NHL among farmers who did not use herbicide.

The relative risk of NHL increased significantly, however, with the number of days of herbicide exposure annually. It also was linked to the nature and intensity of exposure. For example, farmers exposed to herbicides more than 20 days per year had a six-fold higher risk of NHL compared with nonfarmers, and the risk was eight times greater for frequent users who mixed or applied the herbicides themselves.

*(continued)*

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## Non-Hodgkin's lymphoma (continued)

The study found the higher risk of NHL, which will account for an estimated 3% of new US cancer cases and cancer deaths this year, linked mainly to use of phenoxyacetic acid herbicides, especially 2,4-Dichlorophenoxyacetic acid (2, 4-D). Such chemicals are frequently used on pasture land in growing wheat, corn, sorghum, and rice.

"The six-fold excess risk of NHL among high-intensity users of herbicides is cause for concern," the report says, "particularly since the association was mainly for phenoxyacetic acids and was apparent using several different measures of exposure.

"Since over 42 million pounds of phenoxyacetic acid herbicides were applied to US farmlands in 1976, the carcinogenic effects suggested by this study and others have important public health implications," the report concludes.

In an accompanying editorial, Theodore Colton, ScD, of the Boston University School of Public Health, says the report "adds substantially to the cumulating body of evidence concerning the following question: Does human exposure to phenoxyacetic acid herbicides increase the risk of soft-tissue sarcomas, Hodgkin's disease, and non-Hodgkin's lymphoma?"

Colton concludes, "Perhaps the question will never be answered satisfactorily. Whatever direction future results take, it is clear that the report by Hoar et al will have considerable use — and the attendant and inevitable abuse — in the continuing scientific controversy, public debate, and legal battles regarding herbicide exposure and cancer risk." □

Medicine [is] the only profession that labours incessantly to destroy the reason for its own existence.

—Sir James Bryce

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## DEATHS

### Donovan Dillon Mosher, MD

1895 - 1986

Donovan D. Mosher, MD, a Life Member of the OSMA, died in Seminole on April 4, 1986. Dr Mosher, a 1926 graduate of the University of Oklahoma School of Medicine, had been a general practitioner and surgeon in Seminole for many years. He played a prominent role in the planning and construction of Seminole Municipal Hospital.

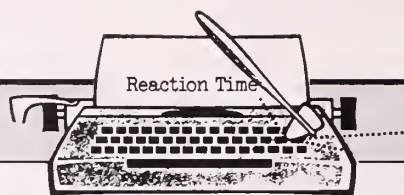
## IN MEMORIAM

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<i>Jesse Ray Waltrip, MD</i>	<i>November 30</i>
<i>Charles F. Obermann, MD</i>	<i>December 30</i>

1986

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<i>Francis M. Duffy, MD</i>	<i>February 5</i>
<i>Edward L. Leonard, MD</i>	<i>February 14</i>
<i>William C. Tisdal, MD</i>	<i>February 24</i>
<i>Donovan Dillon Mosher, MD</i>	<i>April 4</i>
<i>Fred D. Switzer, MD</i>	<i>May 10</i>
<i>Phillip Wade Jones, MD</i>	<i>May 18</i>
<i>Herbert L. Owen, MD</i>	<i>May 28</i>
<i>Marianne Elsbeth Kosbab, MD</i>	<i>June 13</i>
<i>William W. Rucks, Jr., MD</i>	<i>June 27</i>
<i>Ralph A. Smith, MD</i>	<i>July 27</i>
<i>Howard D. Tuttle, MD</i>	<i>August 3</i>



## Reply to August editorial asks "What can physicians do?"

*To the editor:* The closing paragraph of your editorial "Ten Questions" [JOURNAL, Aug 86] states: "If this isn't enough to get your attention, to elicit some response, to create some visible reaction from you, what will it take?"

This reminds me of the story of the person who lived in a fascist state and watched as the storm troopers came to take away different classes of his friends, but he didn't say anything because it didn't involve him; then, when they came to take him away, there was no one left to help.

As you indicate, this incredible Massachusetts law [physicians must accept Medicare assignments or lose their licenses to practice] is almost certain to be appealed to the United States Supreme Court. Therein I think your comments fell short, since most of us are not knowledgeable enough to know what

our response or reaction should be. I believe a subsequent editorial outlining steps to be taken should be forthcoming.

For instance, should each and every one of the 50 state medical associations and the American Medical Association and all other professional medical associations enter into this Supreme Court case as *amicus curiae*? Is the Massachusetts State Medical Society agitating in this regard? How can we as individuals have an effect? Should we be contributing to a special law fund? Etc, etc, etc.

I agree with you that this law is not only a great threat to medical practice but to the freedom we Americans cherish. Please help us to know the best course of action.

Leon Horowitz, MD  
Tulsa



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**The Enchanted Ring. The Untold Story of Penicillin.** By John C. Sheehan. Cambridge, Mass., & London: The MIT Press, 1982, pp 224, \$15.00.

The subtitle of this book is inaccurate in that the story of penicillin has been well told before (for example, see review of *Howard Florey* in *JOSMA* 74:122, 1981). This book is important because it is a detailed account of the author's accomplishments and success in synthesizing penicillin V after others had terminated their efforts. Sheehan, a chemist associated with Merck and later with Massachusetts Institute of Technology, presents interesting portraits of prominent figures in organic chemistry during the 1940s and subsequently.

After the therapeutic value of penicillin G was established, it was presumed that synthesis could be quickly achieved, but this proved to be incorrect. The molecule proved susceptible to many chemicals which destroyed its activity. Fortunately, those responsible for wartime scientific decisions about therapeutic agents wisely chose to proceed with production by fermentation rather than chemical synthesis. In this regard the book presents the vital but often overlooked contributions of Americans to the production of penicillin in quantity during World War II.

Sheehan successfully synthesized penicillin V in 1958 by affecting closure of the beta-lactam ring. The synthesis of penicillin was long delayed because of failure to identify the correct structure of the molecule. Sheehan, often against considerable odds by prominent chemists, adhered to the concept of a molecule with a beta-lactam ring fused to a thiazolidine ring.

The most interesting aspects of this book are the candid comments of the author on contemporary organic chemists and others who were involved in the work on penicillin. It is an interesting account.

*Harris D. Riley, Jr., MD  
Oklahoma City*

### **Life of George Bent: Written from His Letters.**

By George E. Hyde (Savoie Lottinville, ed). Norman: University of Oklahoma Press, 1968; second printing 1983, pp 389, 27 illustrations, 11 maps, price not given.

This book details the very unusual life story of George Bent, son of a white trader and a Cheyenne mother, who chose to live as an Indian warrior in the western plains in the post-Civil War years (1863-1914). George Bent's intimate view of life among the

Cheyenne Indians is embellished by the scholarship of Mr Hyde and the editing of Mr Lottinville.

The opening chapter describes the early history of the Cheyennes, who migrated from the lake country of Minnesota (where they were fish-eaters and used half-wolf dogs as beasts of burden) to the south and west. They acquired various technologies from other tribes: horses in the late eighteenth century, corn culture and hide processing, and steel knives and guns as weapons.

Bent was born in 1843 in eastern Colorado on the upper Arkansas River where his father had a trading post. When he was sent east to Westport (Kansas City) to attend school in 1853, the five-hundred-mile journey was notable for its unspoiled wilderness. Fol-

**There was much  
dishonorable conduct  
by both whites  
and Indians.**

lowing schooling in Westport and at an academy in St Louis, he fought for the Confederacy. At the battle at Corinth in 1862, he was captured and then paroled. On the journey back through Kansas and eastern Colorado to Bent's Fort, he noted that in only nine years a great many settlements, forts, and ranches had been established. The animosity of the pro-Union whites in the vicinity of Bent's Fort convinced him to join his mother's people, a decision reinforced by the punitive raid and massacre of the Cheyennes and Arapahos at Sand Creek in eastern Colorado territory, November 29, 1864, by an army of frontier whites.

The narrative continues through the late 1870s, describing the various migrations and battles of the Cheyennes until the pressure of western settlements circumscribed their nomadic freedom. George Bent and his wife, Magpie, spent the latter portion of their lives in Colony, northeast Washita County, Oklahoma. The account abounds with information on the social structure and life of the Plains Indians. The great importance of rivers in the migrations and life patterns of the tribes is well expressed, as is the central role of horses and buffalo-hunting to the culture. Migrations were extensive, frequently up to the

## Book Shop (continued)

Black Hills and down to the Red River in Indian Territory. Tribal friendships and animosities were firmly fixed. The Cheyennes associated with the Sioux and Arapahos in the north, and with the Kiowas, Comanches, and Plains Apaches in the south.

Bent's description of intertribal warfare and fighting with white soldiers and settlers is surprisingly free of animosity. Raids and pitched battles are interspersed with mingling of whites, half-breed scout warriors, and Indians at conferences, treaty meetings, and trading forts. It is difficult to know whether this restrained attitude is that of Bent or of his biographer. It also becomes evident that there was much dishonorable conduct by both whites and Indians during these years. Many treaty violations by the Indians were caused by youthful hotheads, especially in the Dog Soldiers clan, who led unauthorized raiding parties against white settlers and soldiers and drew down upon themselves and other clans the vengeance of the military. War parties against other In-

dian tribes greatly resembled modern adolescent gang rumbles.

For the medical reader there are descriptions of various great epidemics. In 1780, smallpox spread up the Missouri River killing two-thirds of the Indian population of Western Canada but sparing the Cheyennes. In 1829 or 1830, smallpox struck during the construction of Bent's Fort. The Cheyennes were warned not to visit the area and were saved from the epidemic. They were less fortunate in 1849, when cholera was brought to the Great Plains by the Oregon Trail emigrants. The epidemic spread through the Cheyennes and Sioux, then north through the Platte River Valley to the Blackfeet and south to the Kiowas and Comanches. Half of the Cheyenne people died.

Overall this book is an exciting narrative as well as a detailed social study by an intelligent participant-observer whose life bridged two cultures. Famous semilegendary persons heighten the chronicle: Kit Carson, Wild Bill Hickok, Buffalo Bill Cody, George A. Custer, Sitting Bull, and Yellow Wolf.

*S. R. Oleinick, MD, PhD  
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**Infectious Diseases in General Medical Practice.** Edited by J. Joseph Marr. Menlo Park, Calif, etc: Addison-Wesley Publishing Co., 1982, pp 460, \$29.95.

"Infectious diseases are the most common diseases encountered in general medical practice, accounting for 60%-80% of the illnesses encountered in ambulatory patients," states the preface. The editor and twenty-five contributors have attempted to address the

## There are numerous usable and helpful tables.

large topic of infectious diseases in a workable, brief fashion. The objective is to provide current clinical information in a practical and accessible format. This is done by emphasizing diagnosis and management, with only brief mention of other aspects. At the beginning of each chapter is a brief contents guide giving an outline of the chapter. Marginal notes are interspersed on each page and provide facts and opinions from the text.

The book is divided into twenty chapters. The first six deal with antimicrobial agents. After a chapter discussing the choice of these agents, specific chapters deal with the penicillins, alternatives to penicillin, cephalosporin and aminoglycoside antibiotics, and the use of antibiotics in patients with renal failure. These drugs are discussed from the perspective of the community hospital, and the influence of these agents on the practice of medicine in these hospitals is emphasized.

Immunization is discussed in a separate chapter. The emphasis in this chapter is almost exclusively on adults.

Twelve of the remaining thirteen chapters deal with specific disease entities due to infection. The specific diseases chosen for discussion were selected after consideration of their relative frequencies in ambulatory medical practice and their epidemiologic significance. Some of the chapters are particularly useful and are not usually encountered in textbooks in a separate fashion. These include "Cutaneous Infections," "Nose and Throat Syndromes," and "Sinusitis and Otitis." "Cutaneous Infections," by Arthur White and Joseph Wheat, is particularly useful. Other chapters deal with streptococcal diseases and their sequelae, diagnosis and treatment of pneumonia, viral hepatitis, enteric

diseases, tuberculosis, urinary tract infections, sexually transmitted diseases, infections of the central nervous system, and infectious endocarditis. A final chapter dealing with hospital-acquired infections is succinct and well done.

The references at the end of each chapter are few in number but well selected.

The book contains no illustrations but there are numerous usable and helpful tables. Unfortunately, there are a sizable number of typographical errors, particularly in the references. Certain sentences are poorly constructed.

This book will be of little value to the specialist with training in infectious diseases, but for the primary care physician who encounters these problems, it will be useful. The editor states in the preface that the highest incidence of infection is found in children. Yet, only two of the twenty-five contributors are pediatricians, and the orientation of the book is predominantly toward adults.

Harris D. Riley, Jr., MD  
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(continued)

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## Book Shop (continued)

**Infective Endocarditis and Other Intravascular Infections.** (Current Topics in Infectious Disease). By Lawrence R. Freedman. New York: Plenum Medical Book Co., 1982, pp 243, illustrated.

With the development of potent antimicrobial agents, infectious endocarditis, a disease previously uniformly fatal, became amenable to control and cure. For a time it seemed that intravascular infection would diminish in importance and perhaps be relegated to the infrequent disease category. In recent years, however, important advances such as surgery for congenital and other types of heart disease, the use of intravascular devices and other procedures, and also social deterioration as exhibited by intravenous drug abuse have provided the opportunities for the development of these infections. In many respects, intravascular infections, the most important example of which is infective endocarditis, may be regarded as one of the diseases of medical progress and social evolution.

In eleven chapters and an appendix the author has provided the reader with a comprehensive, up-to-date overview of intravascular infection, with particular attention to infective endocarditis. In the first sections dealing with the pathogenesis of endocarditis, special attention has been placed on the rabbit experimental endocarditis model and the numerous factors which influence the development of infective endocarditis. The author appropriately cautions that the disease in animals can be compared only up to a certain point with the disease in humans.

There is an excellent discussion of the establishment of intravascular infections, including a chart which outlines the numerous causes of bacteremia. The author points out, however, that there is little information available defining the risk of developing endocarditis after a procedure known to produce bacteremia. The section dealing with circulating immune complexes and their clinical and pathological consequences is well done.

The chapter on treatment is comprehensive and quite appropriate for clinical practice. It discusses the dilemma posed by the patient with the clinical picture of endocarditis but negative blood cultures and, in addition to principles of antimicrobial therapy, discusses the special problems with different pathogens. This chapter contains 411 references. It is followed by three useful chapters entitled "Indexes of Effectiveness of Treatment," "Outcome of Treat-

ment," and "Complications of Treatment." The American Heart Association's recommendations for prophylaxis are included in an appendix.

This small book is filled with important information and can be beneficially referred to by all concerned with the many facets of infective endocarditis and other intravascular infections.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**Immunization in Clinical Practice. A Useful Guideline to Vaccines, Sera, and Immune Globulins in Clinical Practice.** Edited by Vincent A. Fulginiti. Philadelphia: J. B. Lippincott Company, 1982, pp 281, \$19.75.

This monograph is edited by Vincent A. Fulginiti and has contributions by four other members of the Department of Pediatrics of the University of Arizona College of Medicine. It begins with five chapters which treat the history of immunization and review immunologic principles, the details of informed consent, the scheduling of immunization, and "practical aspects of immunization practice." The latter covers the establishment of an immunization station, instruction of personnel, recording immunization data and adverse consequences, and other practical features.

Separate chapters deal with individual diseases and immunization against them — diphtheria, pertussis, tetanus, rubella, measles, mumps, and poliomyelitis — the commonly employed agents at the present time. This is followed by a helpful chapter on combinations and simultaneously administration of vaccines. Separate sections on other diseases in which immunization is not employed frequently or routinely follow. These include smallpox, rabies, influenza, tuberculosis, yellow fever, typhoid fever, and bacterial infections such as pneumococcal and meningococcal infections. Another chapter discusses the less frequently used vaccines such as those for cholera, plague, typhus and others. There are two chapters dealing with immune globulin, and a final chapter discusses vaccines in development such as varicella, herpes virus, respiratory virus, hepatitis virus, and others.

This monograph is certainly up to date, comprehensive, and covers the field succinctly but well. It is recommended.

*Harris D. Riley, Jr., MD  
Oklahoma City*

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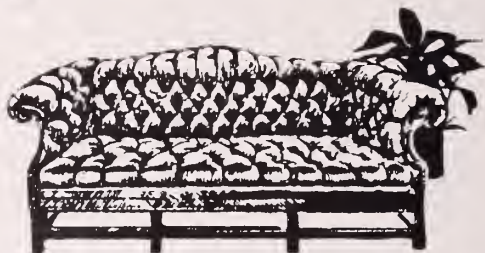
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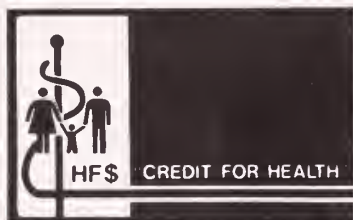
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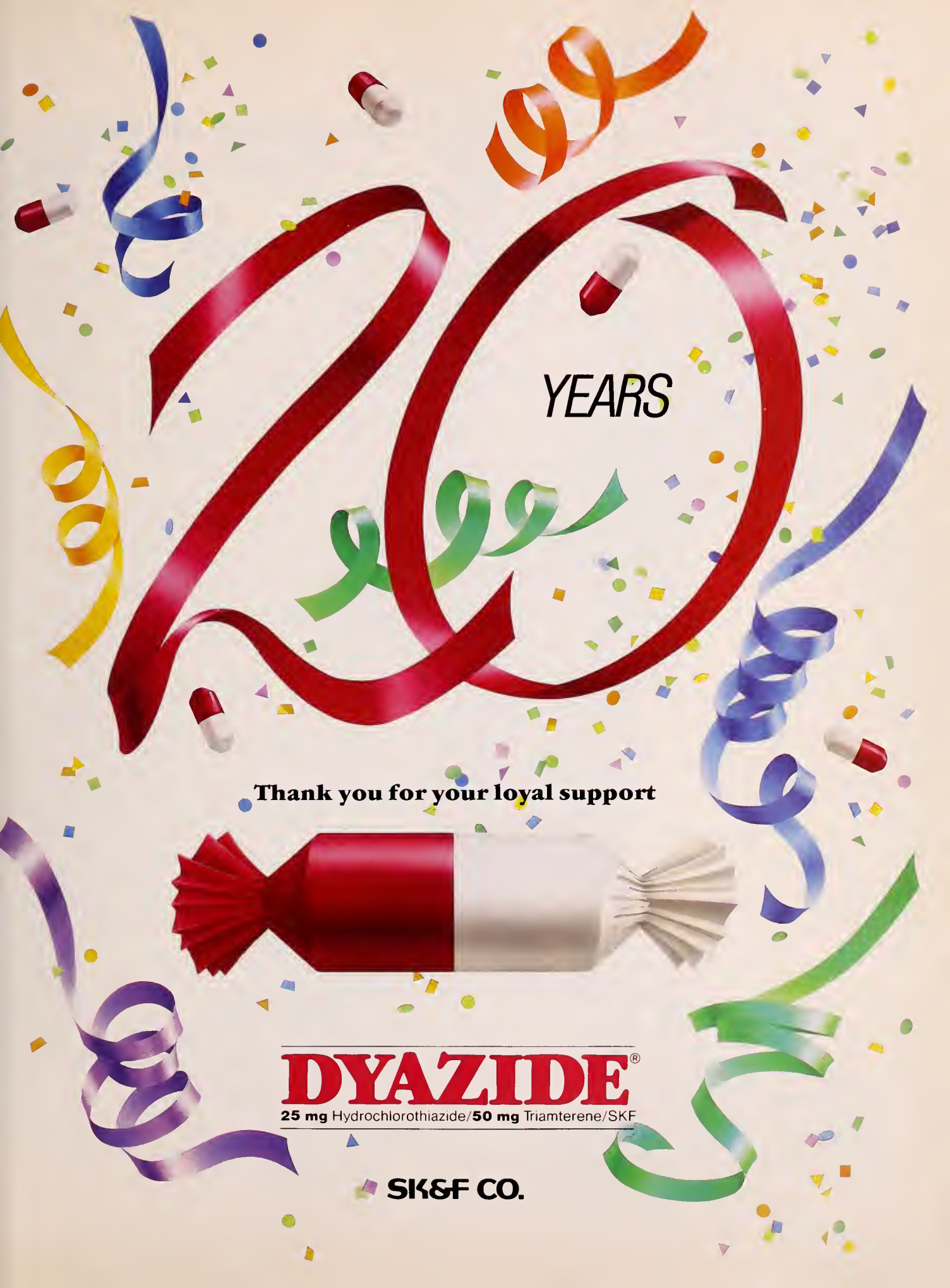
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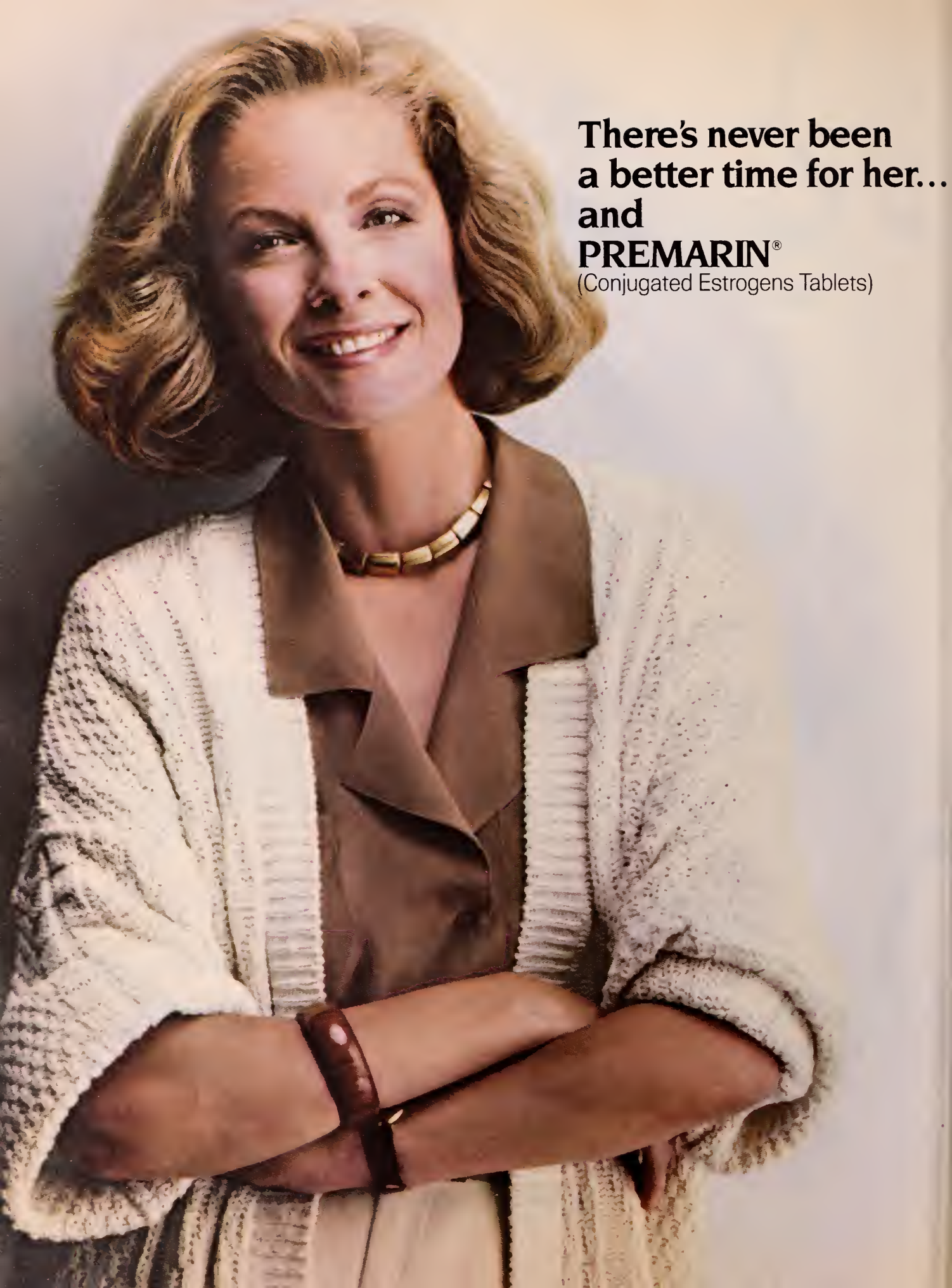
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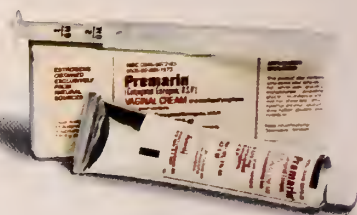
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**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) **Osteoporosis (abnormally low bone mass).** Atrophic vaginitis. Kraurosis vulvae. Female castration.

**PREMARIN (conjugated estrogens) Vaginal Cream** is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use.** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver). There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

**WARNINGS:** Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement, it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with

caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen:

- Increased sulfobromophthalen retention.
- Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased norepinephrine-induced platelet aggregability.
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered.
- Impaired glucose tolerance.
- Decreased pregnandiol excretion.
- Reduced response to metyrapone test.
- Reduced serum folate concentration.
- Increased serum triglyceride and phospholipid concentration. As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea; premenstrual-like syndrome; amenorrhea during and after treatment, increase in size of uterine fibromyomata; vaginal candidiasis; change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating; cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme, erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

**ACUTE OVERDOSSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

### DOSEAGE AND ADMINISTRATION:

**PREMARIN®** Brand of conjugated estrogens tablets, USP

1. *Given cyclically for short-term use only.* For treatment of moderate to severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 1.25 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. *Given cyclically.* Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN®** Brand of conjugated estrogens Vaginal Cream

*Given cyclically for short-term use only.* For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six month intervals.

Usual dosage range 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

### References:

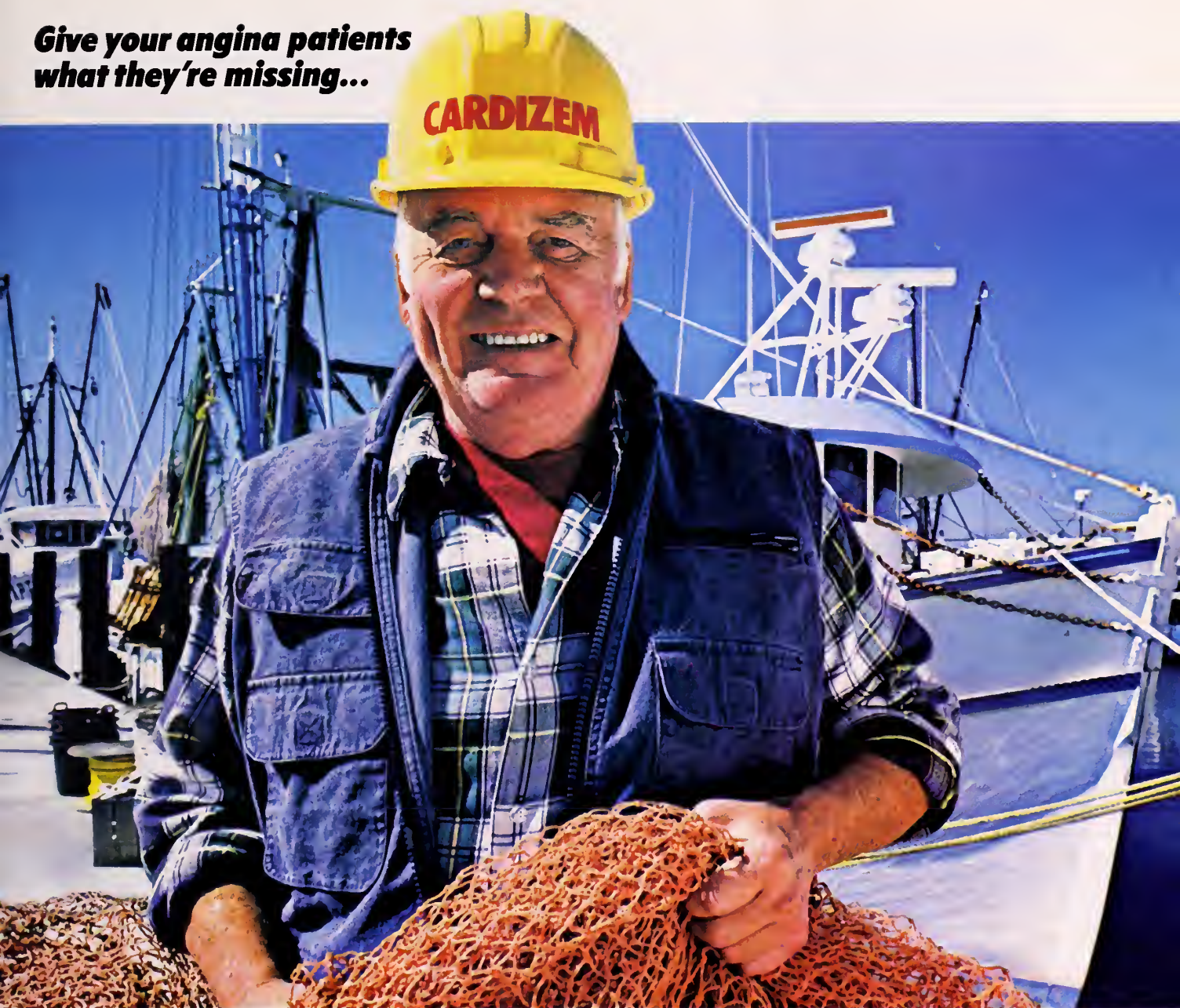
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diltiazem HCl/Marion

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- Proven efficacy when used alone in angina<sup>1</sup>**
- Compatible with other antianginals<sup>2,3\*</sup>**
- A safe choice for angina patients with coexisting hypertension, asthma, COPD, or PVD<sup>4,5</sup>**

**\*See Warnings and Precautions.**

*Please see brief summary of prescribing information on the next page.*



# CARDIZEM<sup>®</sup> FEW SIDE EFFECTS diltiazem HCl/Marion IN ANTIANGINAL THERAPY

60 mg tid or qid

**Brief Summary**  
Professional Use Information

**CARDIZEM<sup>®</sup>**  
(diltiazem HCl) 30 mg and 60 mg Tablets

## CONTRAINDICATIONS

CARDIZEM is contraindicated in (1) patients with sick sinus syndrome except in the presence of a functioning ventricular pacemaker, (2) patients with second- or third-degree AV block except in the presence of a functioning ventricular pacemaker, and (3) patients with hypotension (less than 90 mm Hg systolic).

## WARNINGS

1 **Cardiac Conduction.** CARDIZEM prolongs AV node refractory periods without significantly prolonging sinus node recovery time, except in patients with sick sinus syndrome. This effect may rarely result in abnormally slow heart rates (particularly in patients with sick sinus syndrome) or second- or third-degree AV block (six of 1,243 patients for 0.48%). Concomitant use of diltiazem with beta-blockers or digitalis may result in additive effects on cardiac conduction. A patient with Prinzmetal's angina developed periods of asystole (2 to 5 seconds) after a single dose of 60 mg of diltiazem.

2 **Congestive Heart Failure.** Although diltiazem has a negative inotropic effect in isolated animal tissue preparations, hemodynamic studies in humans with normal ventricular function have not shown a reduction in cardiac index nor consistent negative effects on contractility (dp/dt). Experience with the use of CARDIZEM alone or in combination with beta-blockers in patients with impaired ventricular function is very limited. Caution should be exercised when using the drug in such patients.

3 **Hypotension.** Decreases in blood pressure associated with CARDIZEM therapy may occasionally result in symptomatic hypotension.

4 **Acute Hepatic Injury.** In rare instances, significant elevations in enzymes such as alkaline phosphatase, CPK, LDH, SGOT, SGPT, and other symptoms consistent with acute hepatic injury have been noted. These reactions have been reversible upon discontinuation of drug therapy. The relationship to CARDIZEM is uncertain in most cases, but probable in some. (See PRECAUTIONS.)

## PRECAUTIONS

**General.** CARDIZEM (diltiazem hydrochloride) is extensively metabolized by the liver and excreted by the kidneys and in bile. As with any new drug given over prolonged periods, laboratory parameters should be monitored at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic

function. In subacute and chronic dog and rat studies designed to produce toxicity, high doses of diltiazem were associated with hepatic damage. In special subacute hepatic studies, oral doses of 125 mg/kg and higher in rats were associated with histological changes in the liver which were reversible when the drug was discontinued. In dogs, doses of 20 mg/kg were also associated with hepatic changes; however, these changes were reversible with continued dosing.

**Drug Interaction.** Pharmacologic studies indicate that there may be additive effects in prolonging AV conduction when using beta-blockers or digitalis concomitantly with CARDIZEM. (See WARNINGS.)

Controlled and uncontrolled domestic studies suggest that concomitant use of CARDIZEM and beta-blockers or digitalis is usually well tolerated. Available data are not sufficient, however, to predict the effects of concomitant treatment, particularly in patients with left ventricular dysfunction or cardiac conduction abnormalities. In healthy volunteers, diltiazem has been shown to increase serum digoxin levels up to 20%.

**Carcinogenesis, Mutagenesis, Impairment of Fertility.** A 24-month study in rats and a 21-month study in mice showed no evidence of carcinogenicity. There was also no mutagenic response in *in vitro* bacterial tests. No intrinsic effect on fertility was observed in rats.

**Pregnancy.** Category C. Reproduction studies have been conducted in mice, rats, and rabbits. Administration of doses ranging from five to ten times greater (on a mg/kg basis) than the daily recommended therapeutic dose has resulted in embryo and fetal lethality. These doses, in some studies, have been reported to cause skeletal abnormalities. In the perinatal/postnatal studies, there was some reduction in early individual pup weights and survival rates. There was an increased incidence of stillbirths at doses of 20 times the human dose or greater.

There are no well-controlled studies in pregnant women, therefore, use CARDIZEM in pregnant women only if the potential benefit justifies the potential risk to the fetus.

**Nursing Mothers.** Diltiazem is excreted in human milk. One report suggests that concentrations in breast milk may approximate serum levels. If use of CARDIZEM is deemed essential, an alternative method of infant feeding should be instituted.

**Pediatric Use.** Safety and effectiveness in children have not been established.

## ADVERSE REACTIONS

Serious adverse reactions have been rare in studies carried out to date, but it should be recognized that patients with impaired ventricular function and cardiac conduction abnormalities have usually been excluded.

In domestic placebo-controlled trials, the incidence of adverse reactions reported during CARDIZEM therapy was not greater than that reported during placebo therapy.

The following represent occurrences observed in clinical studies which can be at least reasonably asso-

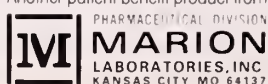
ciated with the pharmacology of calcium influx inhibition. In many cases, the relationship to CARDIZEM has not been established. The most common occurrences as well as their frequency of presentation are: edema (2.4%), headache (2.1%), nausea (1.9%), dizziness (1.5%), rash (1.3%), asthenia (1.2%). In addition, the following events were reported infrequently (less than 1%):

Cardiovascular	Angina, arrhythmia, AV block (first degree), AV block (second or third degree — see conduction warning), bradycardia, congestive heart failure, flushing, hypotension, palpitations, syncope
Nervous System	Amnesia, gait abnormality, hallucinations, insomnia, nervousness, paresthesia, personality change, somnolence, tinnitus, tremor
Gastrointestinal	Anorexia, constipation, diarrhea, dysgeusia, dyspepsia, mild elevations of alkaline phosphatase, SGOT, SGPT, and LDH (see hepatic warnings), vomiting, weight increase
Dermatologic	Petechiae, pruritus, photosensitivity, urticaria
Other	Amblyopia, dyspnea, epistaxis, eye irritation, hyperglycemia, nasal congestion, nocturia, osteoarthralgia, pain, polyuria, sexual difficulties

The following postmarketing events have been reported infrequently in patients receiving CARDIZEM: alopecia, gingival hyperplasia, erythema multiforme, and leukopenia. However, a definitive cause and effect between these events and CARDIZEM therapy is yet to be established. **Issued 7/86**  
See complete Professional Use Information before prescribing.

**References:** 1. Pepine CJ, Feldman RL, Hill JA, et al. Clinical outcome after treatment of rest angina with calcium blockers. Comparative experience during the initial year of therapy with diltiazem, nifedipine, and verapamil. *Am Heart J* 1983; 106(6): 1341-1347. 2. Shapiro W. Calcium channel blockers: Actions on the heart and uses in ischemic heart disease. *Consultant* 1984; 24(Dec): 150-159. 3. Johnston DL, Lesoway R, Humen DP, et al. Clinical and hemodynamic evaluation of propranolol in combination with verapamil, nifedipine and diltiazem in exertional angina pectoris. A placebo-controlled, double-blind, randomized, crossover study. *Am J Cardiol* 1985; 55: 680-687. 4. Cohn PF, Braunwald E. Chronic ischemic heart disease. In: Braunwald E (ed). *Heart Disease. A Textbook of Cardiovascular Medicine* ed 2. Philadelphia, WB Saunders Co, 1984: chap. 39. 5. Schroeder JS. Calcium and beta blockers in ischemic heart disease: When to use which. *Mod Med* 1982; 50(Sept): 94-116.

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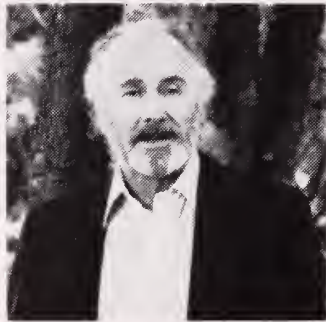
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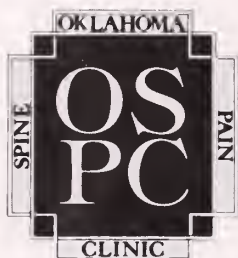
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Articles submitted for publication, including Annual Meeting papers, become the sole property of the JOURNAL and must not have been published elsewhere. The Editorial Board reserves the right to edit any material submitted. Manuscripts must be typewritten, double-spaced, and submitted in duplicate. Receipt of manuscripts will be acknowledged, and unpublished manuscripts will be returned. The JOURNAL does not assume responsibility for the statements or opinions of any contributor.

### Style

All manuscripts should adhere to the style adopted by the American Medical Association as illustrated in *JAMA* and detailed in the AMA's *Manual for Authors & Editors*. Footnotes, bibliographies, and legends for illustrations should be typewritten, double-spaced, on separate sheets. References are to be listed in the order of their appearance in the article.

### Illustrations

Illustrations other than the author's will not be accepted for publication unless accompanied by written permission from the original source. Illustrations should be labeled with the author's name and must be numbered in the order in which they are referred to in the article. The quality of all illustrations must be in keeping with the quality of the magazine.

### News

Readers are encouraged to submit news items of interest to Oklahoma physicians. Where dates of meetings, etc., are important, please remember that each issue closes on the first day of the *preceding* month and reaches subscribers in the latter half of the month of publication.

### Reprints

Authors will receive reprint order forms from the Transcript Press, 222 East Eufaula, Norman, Oklahoma 73069, prior to publication of their articles. Other requests for reprints must be made to the Transcript Press within 30 days after publication.

### Back Issues

Microfilm copies of back issues of the JOURNAL can be purchased from University Microfilms International, 300 North Zeeb Road, Ann Arbor, Michigan 48106.

## Report of 1986 activities

As a member of the OSMA, you must be interested in what the State Medical Association Auxiliary is doing to activate its members to participate in legislative issues. We began the formation of a legislative action committee in October of 1985 with discussions on what we, as an auxiliary, could accomplish and how we could help the lobbying efforts of the state and local medical associations. Since these meager discussions we have become an "action committee" and started the process of legislative education of our members statewide.

The committee has met monthly, with an action goal which is accomplished by the next month. We now have a group of ten women whose job it is to help set up statewide local legislative action committees. The committee members are resource people for such things as publicity, telephone banks, information retrieval, education, speakers' bureau, fund development, and correspondence. The members are becoming experts on the legislative process and how to affect the process locally.

We hope to develop a network which the OSMA can use to enable it to find MDs who are willing to be involved at the county level with their local legislators. The county auxiliaries will be educated on

how to best help their local medical societies to approach and talk with legislators about the issues.

The legislative action committee is working closely with OMPAC to help its members develop the resources necessary to be used as the occasion warrants. Also, local auxiliaries are being instructed to find local sources of revenue which can be tapped when the need arises.

In addition to monetary resources we are now beginning to look more closely at local support outside the medical community. Our strategy is to identify as many resources as possible and begin using them in our network. We have already used the phone bank, which is being encouraged by the national auxiliary, to defeat a piece of federal legislation.

Ours is a large undertaking needing a great deal of education of its members. But we should be ready to help the lobbying efforts of the OSMA for the next year, at least in a small way. We hope we will continue to grow and gather strength over the next few years and become a force with the OSMA.

*Jacque Tomsovic*  
*Legislative Action Committee*

---

## THE LAST WORD

■ An article by Tulsa cardiologist James R. Higgins, MD, appears in the August issue of the *Journal of the American College of Cardiology*. The article is entitled "Automatic Burst Extrastimulus Pacemaker to Treat Recurrent Ventricular Tachycardia in a Patient with Mitral Valve Prolapse: More Than 2,000 Documented Successful Tachycardia Terminations."

■ In the wake of the Chernobyl accident in the Soviet Union, the American Medical Association has organized the First International Conference on Radiation Emergencies. The purpose of the conference, November 19-21, is to prepare the medical community for potential radiation emergencies. Those interested in attending the Washington, DC, meeting should call (800) 621-8335.

■ Total health care spending in the US rose 8.9% in 1985, the lowest rate of increase in two decades, according to a report published in September's "Health Care Financing Review." At the same time, however, health care costs consumed a greater proportion than ever (10.7%) of the gross national product and continued to grow at more than twice the overall inflation rate in the rest of the economy.

■ As surgical procedures become generally safer and more commonplace, more patients have been recognized who repeatedly seek unnecessary surgery, according to a report in the *Archives of Otolaryngology—Head and Neck Surgery*. Mary Ruth Wright, PhD, of Baylor College of Medicine, Houston, says such patients may suffer low self-esteem and feelings of inadequacy in personal, sexual, and work relationships. "Surgery is not a solution to psychological conflicts," she observes. "On the contrary, it may destroy the patient's meager means of coping with his shaky life." Noting that polysurgical addiction was first established as a medical entity by Karl Menninger in 1934, Wright adds, "It must be the surgeon's, not the patient's responsibility to prevent unnecessary surgery."

■ Corneal inflammation (keratitis) may be a long-term risk of radial keratotomy, according to two reports in the *Archives of Ophthalmology*. Such unexpected complications may further dampen enthusiasm for the surgical procedure to correct nearsightedness, say Ira A. Shivitz, MD, and Peter N. Arrowsmith, MD, of Arrowsmith Eye Institute, Nashville. Although other complications have been associated with the surgery, the researchers believe theirs is the first report of delayed keratitis. Inflammation may occur because the surgical wounds heal slowly and because cysts sometimes form in the incisions as they heal, the doctors suggest. In a related article in the same issue, Sid Mandelbaum, MD, of the University of Miami School of Medicine, and colleagues report three cases of ulcerative keratitis that occurred seven months to 2½ years after uncomplicated radial keratotomy. With therapy, all ulcers healed without reducing visual acuity. "Late corneal ulceration is a complication of radial keratotomy that we had not anticipated," the researchers say. "The recent recognition of this entity emphasizes the need for careful, long-term follow-up of patients who have undergone radial keratotomy to detect unexpected complications."

■ Patients who participate in outpatient cardiac rehabilitation programs may be reassured that heart attacks related to such exercise are extremely rare. A four-year study of 167 such programs, published in the *Journal of the American Medical Association*, revealed 21 cardiac arrests (three of which were fatal), and 8 nonfatal myocardial infarctions. The programs included 51,303 patients who exercised 2,351,916 hours from January 1980 through December 1984. "These data indicate that current cardiac rehabilitation practice allows for prescribed supervised exercise by patients with cardiovascular disease to be performed at a low risk of major cardiovascular complications," say Steven P. Van Camp, MD, of San Diego State University, and Richard A. Peterson, PhD, of Alvarado Hospital Medical Center, San Diego. □

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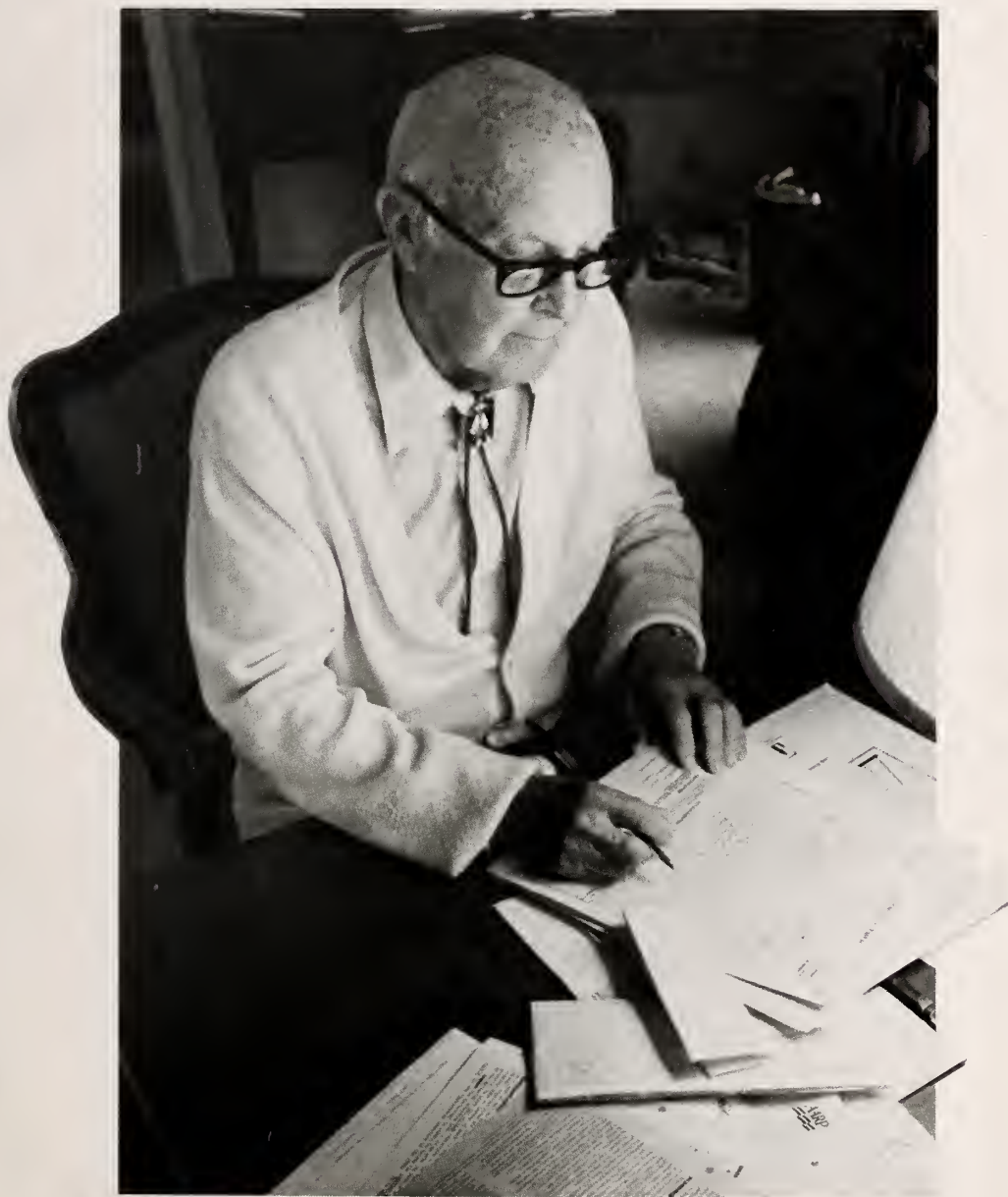
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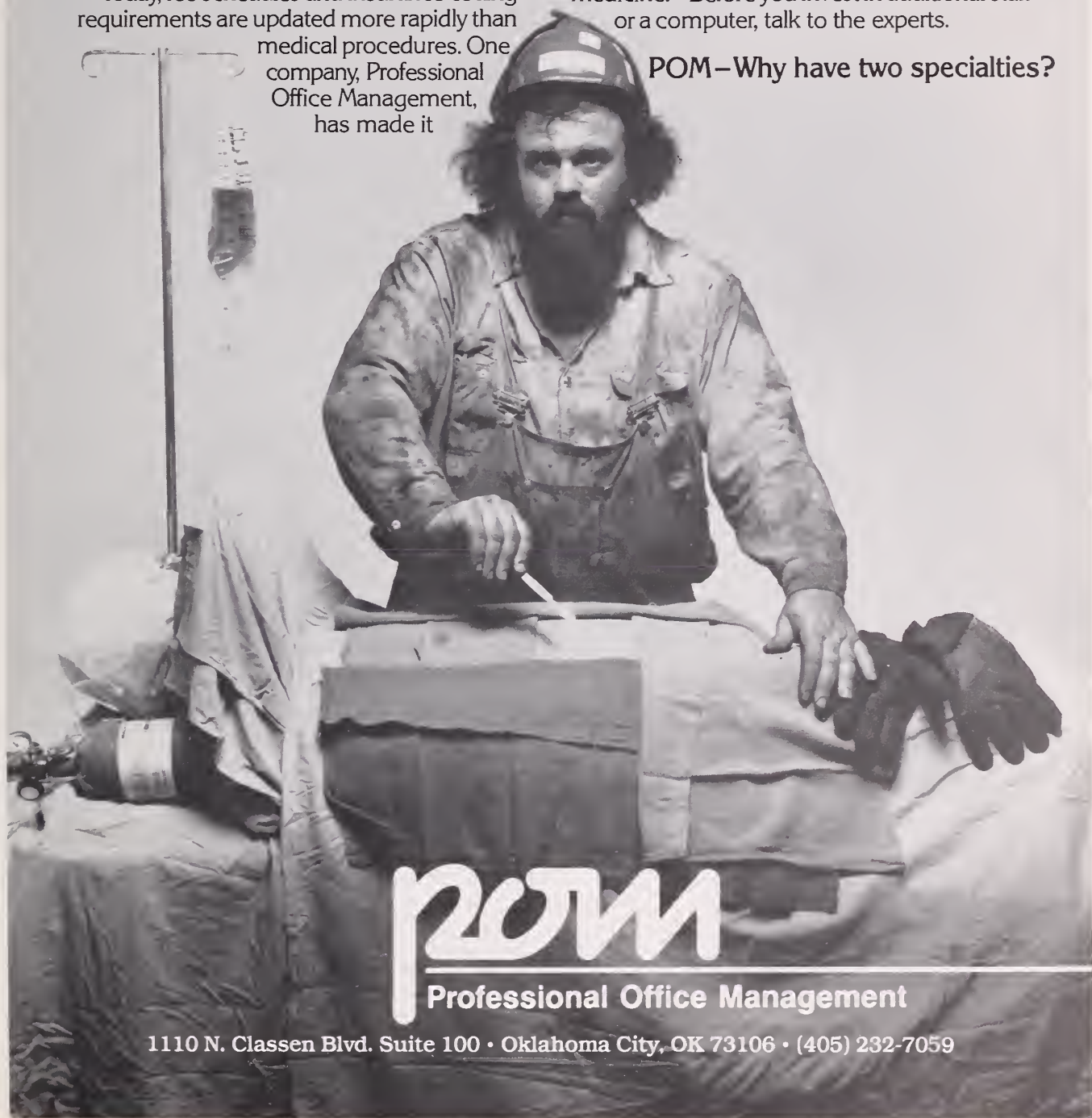
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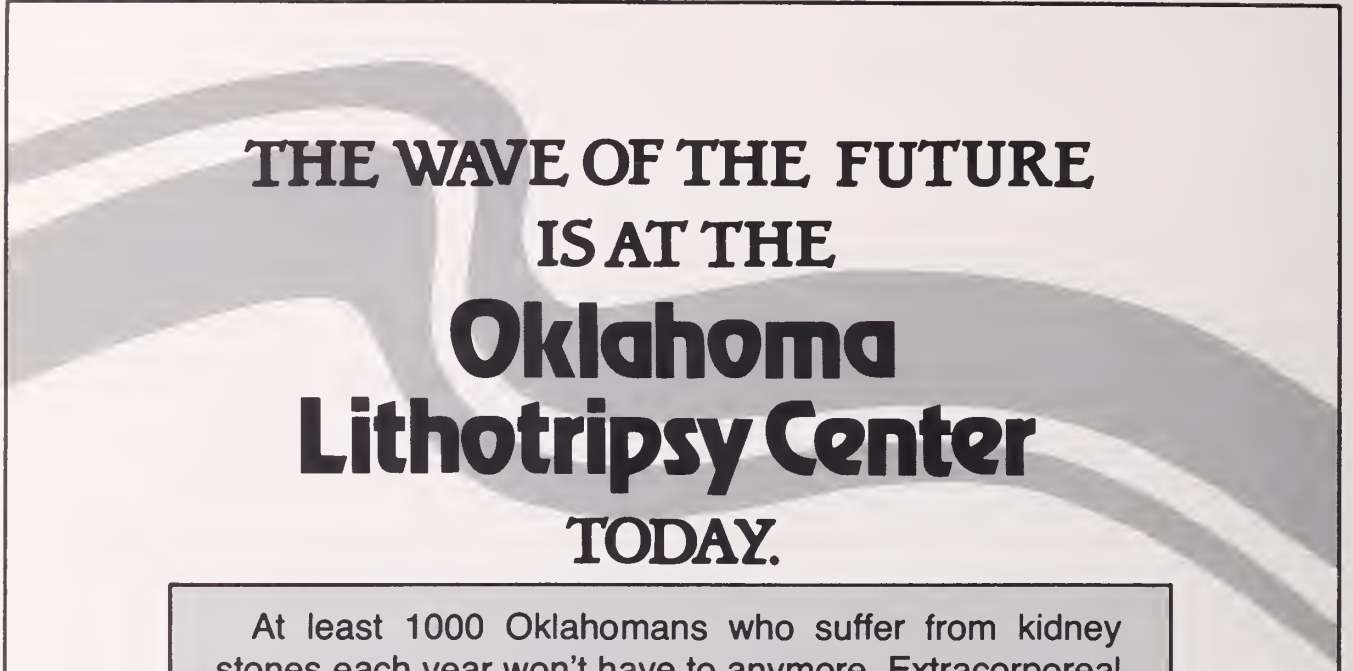
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# JOURNAL

OKLAHOMA STATE MEDICAL ASSOCIATION

NOVEMBER 1986

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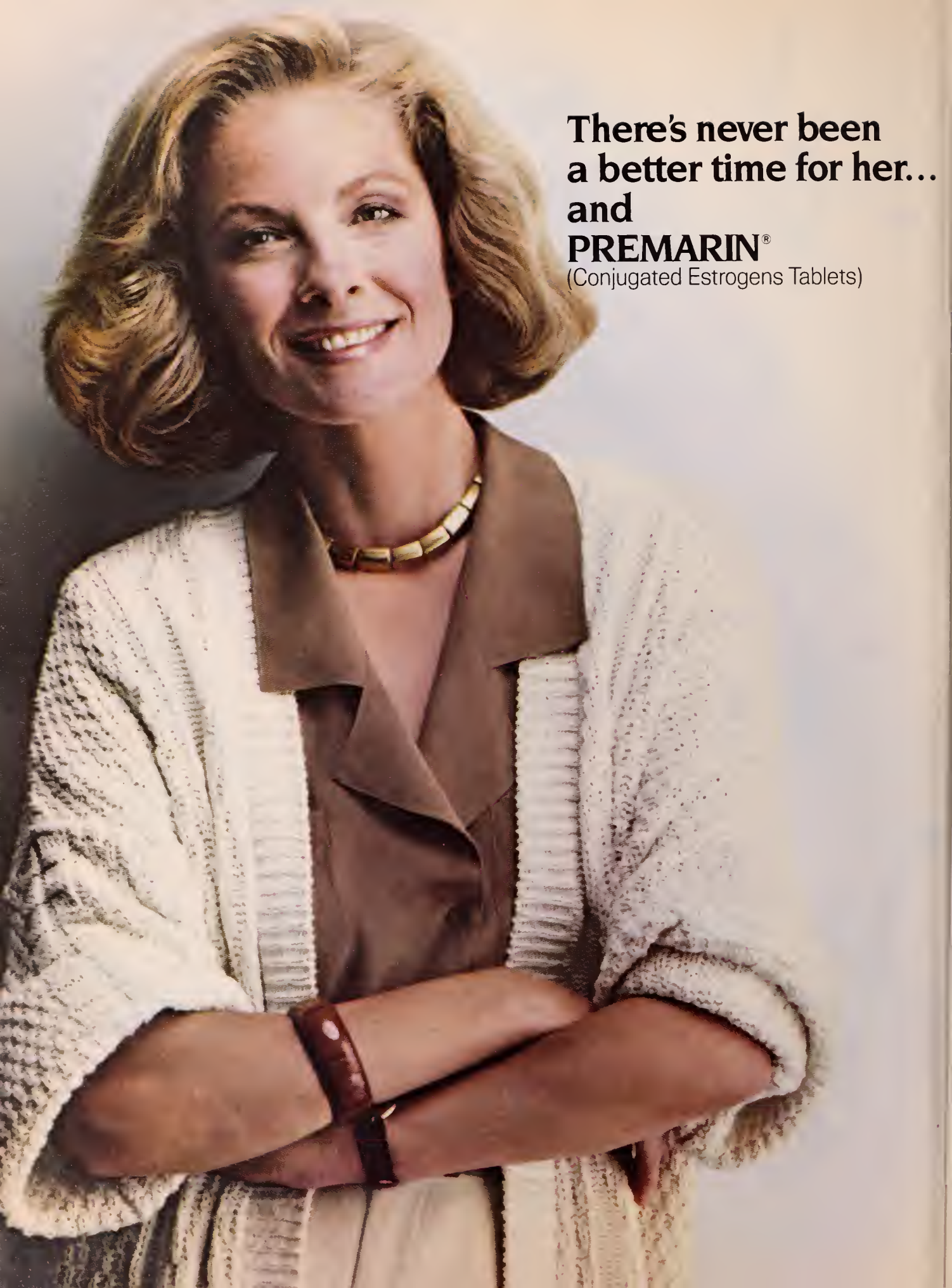
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### 1. ESTROGENS HAVE BEEN REPORTED TO INCREASE THE RISK OF ENDOMETRIAL CARCINOMA

Three independent case control studies have reported an increased risk of endometrial cancer in postmenopausal women exposed to exogenous estrogens for more than one year. This risk was independent of the other known risk factors for endometrial cancer. These studies are further supported by the finding that incidence rates of endometrial cancer have increased sharply since 1969 in eight different areas of the United States with population-based cancer reporting systems, an increase which may be related to the rapidly expanding use of estrogens during the last decade. The three case control studies reported that the risk of endometrial cancer in estrogen users was about 4 to 13.9 times greater than in nonusers. The risk appears to depend on both duration of treatment and on estrogen dose. In view of these findings, when estrogens are used for the treatment of menopausal symptoms, the lowest dose that will control symptoms should be utilized and medication should be discontinued as soon as possible. When prolonged treatment is medically indicated, the patient should be reassessed on at least a semiannual basis to determine the need for continued therapy. Although the evidence must be considered preliminary, one study suggests that cyclic administration of low doses of estrogen may carry less risk than continuous administration; it therefore appears prudent to utilize such a regimen. Close clinical surveillance of all women taking estrogens is important. In all cases of undiagnosed persistent or recurring abnormal vaginal bleeding, adequate diagnostic measures should be undertaken to rule out malignancy. There is no evidence at present that "natural" estrogens are more or less hazardous than "synthetic" estrogens at equieffective doses.

### 2. ESTROGENS SHOULD NOT BE USED DURING PREGNANCY

The use of female sex hormones, both estrogens and progestogens, during early pregnancy may seriously damage the offspring. It has been shown that females exposed in utero to diethylstilbestrol, a non-steroidal estrogen, have an increased risk of developing in later life a form of vaginal or cervical cancer that is ordinarily extremely rare. This risk has been estimated as not greater than 4 per 1,000 exposures. Furthermore, a high percentage of such exposed women (from 30% to 90%) have been found to have vaginal adenosis, epithelial changes of the vagina and cervix. Although these changes are histologically benign, it is not known whether they are precursors of malignancy. Although similar data are not available with the use of other estrogens, it cannot be presumed they would not induce similar changes. Several reports suggest an association between intrauterine exposure to female sex hormones and congenital anomalies, including congenital heart defects and limb reduction defects. One case control study estimated a 4.7-fold increased risk of limb reduction defects in infants exposed in utero to sex hormones (oral contraceptives, hormone withdrawal tests for pregnancy, or attempted treatment for threatened abortion). Some of these exposures were very short and involved only a few days of treatment. The data suggest that the risk of limb reduction defects in exposed fetuses is somewhat less than 1 per 1,000. In the past, female sex hormones have been used during pregnancy in an attempt to treat threatened or habitual abortion. There is considerable evidence that estrogens are ineffective for these indications, and there is no evidence from well controlled studies that progestogens are effective for these uses. If PREMARIN is used during pregnancy, or if the patient becomes pregnant while taking this drug, she should be apprised of the potential risks to the fetus, and the advisability of pregnancy continuation.

**DESCRIPTION:** PREMARIN (conjugated estrogens, USP) contains a mixture of estrogens, obtained exclusively from natural sources, blended to represent the average composition of material derived from pregnant mares' urine. It contains estrone, equilin, and 17 $\alpha$ -dihydroequilin, together with smaller amounts of 17 $\alpha$ -estradiol, equilin, and 17 $\alpha$ -dihydroequilin as salts of their sulfate esters. Tablets are available in 0.3 mg, 0.625 mg, 0.9 mg, 1.25 mg, and 2.5 mg strengths of conjugated estrogens. Cream is available as 0.625 mg conjugated estrogens per gram.

**INDICATIONS AND USAGE:** PREMARIN (conjugated estrogens tablets, USP): Moderate-to-severe vasomotor symptoms associated with the menopause. (There is no evidence that estrogens are effective for nervous symptoms or depression without associated vasomotor symptoms and they should not be used to treat such conditions.) Osteoporosis (abnormally low bone mass). Atrophic vaginitis. Kraurosis vulvae. Female castration.

PREMARIN (conjugated estrogens) Vaginal Cream is indicated in the treatment of atrophic vaginitis and kraurosis vulvae. PREMARIN HAS NOT BEEN SHOWN TO BE EFFECTIVE FOR ANY PURPOSE DURING PREGNANCY AND ITS USE MAY CAUSE SEVERE HARM TO THE FETUS (SEE BOXED WARNING).

**Concomitant Progestin Use:** The lowest effective dose appropriate for the specific indication should be utilized. Studies of the addition of a progestin for 7 or more days of a cycle of estrogen administration have reported a lowered incidence of endometrial hyperplasia. Morphological and biochemical studies of the endometrium suggest that 10 to 13 days of progestin are needed to provide maximal maturation of the endometrium and to eliminate any hyperplastic changes. Whether this will provide protection from endometrial carcinoma has not been clearly established. There are possible additional risks which may be associated with the inclusion of progestin in estrogen replacement regimens. (See PRECAUTIONS.) The choice of progestin and dosage may be important; product labeling should be reviewed to minimize possible adverse effects.

**CONTRAINDICATIONS:** Estrogens should not be used in women (or men) with any of the following conditions: 1. Known or suspected cancer of the breast except in appropriately selected patients being treated for metastatic disease. 2. Known or suspected estrogen-dependent neoplasia. 3. Known or suspected pregnancy (See Boxed Warning). 4. Undiagnosed abnormal genital bleeding. 5. Active thrombophlebitis or thromboembolic disorders. 6. A past history of thrombophlebitis, thrombosis, or thromboembolic disorders associated with previous estrogen use (except when used in treatment of breast or prostatic malignancy).

**WARNINGS:** Long-term continuous administration of natural and synthetic estrogens in certain animal species increases the frequency of carcinomas of the breast, cervix, vagina, and liver. There are now reports that estrogens increase the risk of carcinoma of the endometrium in humans. (See Boxed Warning.) At the present time there is no satisfactory evidence that estrogens given to postmenopausal women increase the risk of cancer of the breast, although a recent study has raised this possibility. There is a need for caution in prescribing estrogens for women with a strong family history of breast cancer or who have breast nodules, fibrocystic disease, or abnormal mammograms. A recent study has reported a 2- to 3-fold increase in the risk of surgically confirmed gallbladder disease in women receiving postmenopausal estrogens.

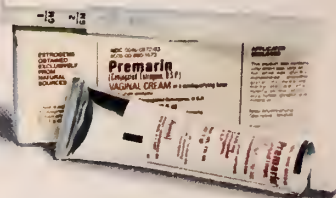
Adverse effects of oral contraceptives may be expected at the larger doses of estrogen used to treat prostatic or breast cancer or postpartum breast engorgement; it has been shown that there is an increased risk of thrombosis in men receiving estrogens for prostatic cancer and women for postpartum breast engorgement. Users of oral contraceptives have an increased risk of diseases, such as thrombophlebitis, pulmonary embolism, stroke, and myocardial infarction. Cases of retinal thrombosis, mesenteric thrombosis, and optic neuritis have been reported in oral contraceptive users. An increased risk of postsurgery thromboembolic complications has also been reported in users of oral contraceptives. If feasible, estrogen should be discontinued at least 4 weeks before surgery of the type associated with an increased risk of thromboembolism, or during periods of prolonged immobilization. Estrogens should not be used in persons with active thrombophlebitis, thromboembolic disorders, or in persons with a history of such disorders in association with estrogen use. They should be used with

For atrophic vaginitis

## PREMARIN® (Conjugated Estrogens)

Vaginal  
Cream

0.625mg/g



caution in patients with cerebral vascular or coronary artery disease. Large doses (5 mg conjugated estrogens per day), comparable to those used to treat cancer of the prostate and breast, have been shown to increase the risk of nonfatal myocardial infarction, pulmonary embolism and thrombophlebitis. When doses of this size are used, any of the thromboembolic and thrombotic adverse effects should be considered a clear risk.

Benign hepatic adenomas should be considered in estrogen users having abdominal pain and tenderness, abdominal mass, or hypovolemic shock. Hepatocellular carcinoma has been reported in women taking estrogen-containing oral contraceptives. Increased blood pressure may occur with use of estrogens in the menopause and blood pressure should be monitored with estrogen use. A worsening of glucose tolerance has been observed in patients on estrogen-containing oral contraceptives. For this reason, diabetic patients should be carefully observed. Estrogens may lead to severe hypercalcemia in patients with breast cancer and bone metastases.

**PRECAUTIONS:** Physical examination and a complete medical and family history should be taken prior to the initiation of any estrogen therapy with special reference to blood pressure, breasts, abdomen, and pelvic organs, and should include a Papanicolaou smear. As a general rule, estrogen should not be prescribed for longer than one year without another physical examination being performed. Conditions influenced by fluid retention such as asthma, epilepsy, migraine, and cardiac or renal dysfunction, require careful observation. Certain patients may develop manifestations of excessive estrogenic stimulation, such as abnormal or excessive uterine bleeding, mastodynia, etc. Prolonged administration of unopposed estrogen therapy has been reported to increase the risk of endometrial hyperplasia in some patients. Oral contraceptives appear to be associated with an increased incidence of mental depression. Patients with a history of depression should be carefully observed. Preexisting uterine leiomyomata may increase in size during estrogen use. The pathologist should be advised of estrogen therapy when relevant specimens are submitted. If jaundice develops in any patient receiving estrogen, the medication should be discontinued while the cause is investigated. Estrogens should be used with care in patients with impaired liver function, renal insufficiency, metabolic bone diseases associated with hypercalcemia, or in young patients in whom bone growth is not complete. If concomitant progestin therapy is used, potential risks may include adverse effects on carbohydrate and lipid metabolism.

The following changes may be expected with larger doses of estrogen.

- Increased sulfobromophthalen retention
- Increased prothrombin and factors VII, VIII, IX, and X, decreased antithrombin 3; increased norepinephrine-induced platelet aggregability
- Increased thyroid binding globulin (TBG) leading to increased circulating total thyroid hormone, as measured by PBI, T4 by column, or T4 by radioimmunoassay. Free T3 resin uptake is decreased, reflecting the elevated TBG; free T4 concentration is unaltered
- Impaired glucose tolerance
- Decreased pregnandiol excretion
- Reduced response to metyrapone test
- Reduced serum folate concentration
- Increased serum triglyceride and phospholipid concentration

As a general principle, the administration of any drug to nursing mothers should be done only when clearly necessary since many drugs are excreted in human milk.

**ADVERSE REACTIONS:** The following have been reported with estrogenic therapy, including oral contraceptives: breakthrough bleeding, spotting, change in menstrual flow, dysmenorrhea, premenstrual-like syndrome, amenorrhea during and after treatment; increase in size of uterine fibromyomata; vaginal candidiasis, change in cervical erosion and in degree of cervical secretion; cystitis-like syndrome; tenderness, enlargement, secretion (of breasts); nausea, vomiting, abdominal cramps, bloating, cholestatic jaundice; chloasma or melasma which may persist when drug is discontinued; erythema multiforme; erythema nodosum; hemorrhagic eruption; loss of scalp hair; hirsutism; steepening of corneal curvature; intolerance to contact lenses; headache, migraine, dizziness, mental depression, chorea; increase or decrease in weight; reduced carbohydrate tolerance; aggravation of porphyria; edema; changes in libido.

**ACUTE OVERDOSSAGE:** May cause nausea, and withdrawal bleeding may occur in females.

### DOSEAGE AND ADMINISTRATION:

**PREMARIN®** Brand of conjugated estrogens tablets, USP

1. Given cyclically for short-term use only. For treatment of moderate to severe vasomotor symptoms, atrophic vaginitis, or kraurosis vulvae associated with the menopause (0.3 to 2.5 mg or more daily). The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible. Administration should be cyclic (eg, three weeks on and one week off). Attempts to discontinue or taper medication should be made at three- to six-month intervals.

2. Given cyclically. Female castration. Osteoporosis. Female castration—1.25 mg daily, cyclically. Adjust upward or downward according to response of the patient. For maintenance, adjust dosage to lowest level that will provide effective control. Osteoporosis—0.625 mg daily. Administration should be cyclic (eg, three weeks on and one week off).

Patients with an intact uterus should be monitored for signs of endometrial cancer and appropriate measures taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

**PREMARIN®** Brand of conjugated estrogens Vaginal Cream

Given cyclically for short-term use only. For treatment of atrophic vaginitis or kraurosis vulvae.

The lowest dose that will control symptoms should be chosen and medication should be discontinued as promptly as possible.

Administration should be cyclic (eg, three weeks on and one week off).

Attempts to discontinue or taper medication should be made at three-to-six-month intervals. Usual dosage range: 2 to 4 g daily, intravaginally, depending on the severity of the condition.

Treated patients with an intact uterus should be monitored closely for signs of endometrial cancer and appropriate diagnostic measures should be taken to rule out malignancy in the event of persistent or recurring abnormal vaginal bleeding.

### References:

- Whitehead MI, Townsend PT, Pryse-Owies J, et al. Effects of estrogens and progestins on the biochemistry and morphology of the postmenopausal endometrium. *N Engl J Med* 1981;305:1599-1605.
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Every day more and more  
physicians are hearing  
something remarkable  
from some of their  
hypertensive patients...

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**SILENCE...**

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**INDERAL<sup>®</sup> LA**  
(PROPRANOLOL HCl)

with a side-effect profile unsurpassed  
by atenolol or metoprolol.

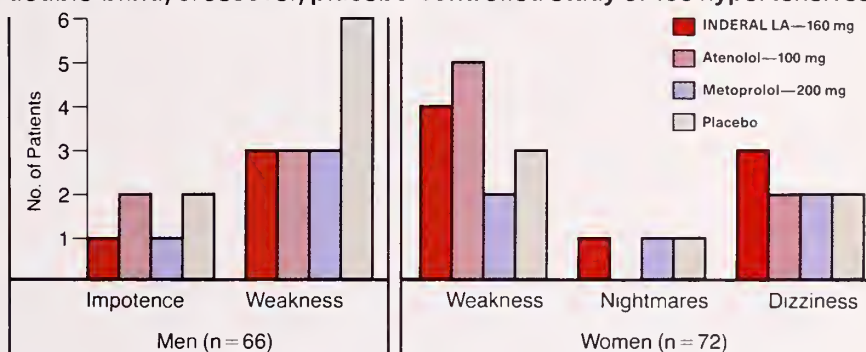
As seen in this double-blind, crossover, placebo-controlled study.<sup>1</sup>

Which shows you how truly well tolerated once-daily INDERAL LA can be.

What comes as *no* surprise, of course, is that it gives you the antihypertensive effectiveness you've come to expect from INDERAL.

**Selected Side Effects**

**INDERAL LA as well tolerated as atenolol and metoprolol in a double-blind, crossover, placebo-controlled study of 138 hypertensives<sup>1</sup>**



INDERAL<sup>®</sup> LA. For control.  
*Comfortable* control. Once a day.  
It's the last word.

Hypertensives: Feeling well and  
doing well, all in one.

**INDERAL<sup>®</sup> LA**  
(PROPRANOLOL HCl) LONG ACTING CAPSULES

or

**INDERIDE<sup>®</sup> LA**  
(PROPRANOLOL HCl [INDERAL<sup>®</sup> LA]/  
HYDROCHLOROTHIAZIDE) LONG ACTING CAPSULES

As with all fixed-combination antihypertensives, INDERIDE LA is not indicated for the initial treatment of hypertension.

INDERAL LA should not be used in the presence of congestive heart failure, sinus bradycardia, cardiogenic shock, heart block greater than first degree, and bronchial asthma.

Please turn page for brief summary of prescribing information.

# Feeling well and doing well, all in one.

**ONCE-DAILY** LONG ACTING CAPSULES

**INDERAL® LA**  
(PROPRANOLOL HCl)



**ONCE-DAILY** LONG ACTING CAPSULES

**INDERIDE® LA**

Each capsule contains propranolol HCl (INDERAL® LA), 80 mg, 120 mg, or 160 mg, and hydrochlorothiazide, 50 mg



**BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULARS.)**

**INDERAL® LA** Brand of PROPRANOLOL HYDROCHLORIDE (Long Acting Capsules)  
**INDERIDE® LA** Brand of PROPRANOLOL HYDROCHLORIDE (INDERAL® LA) and HYDROCHLOROTHIAZIDE (Long Acting Capsules)

INDERAL LA and Inderide LA Capsules should not be considered simple mg-for-mg substitutes for Inderal and Inderide Tablets. Please see package circulars.

## CONTRAINDICATIONS

**Propranolol hydrochloride (INDERAL® LA):** Propranolol is contraindicated in 1) cardiogenic shock, 2) sinus bradycardia and greater than first degree block, 3) bronchial asthma, 4) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol.

**Hydrochlorothiazide:** Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

## WARNINGS

**Propranolol hydrochloride (INDERAL® LA):** CARDIAC FAILURE Sympathetic stimulation may be a vital component supporting circulatory function in patients with congestive heart failure, and its inhibition by beta blockade may precipitate more severe failure. Although beta blockers should be avoided in overt congestive heart failure, if necessary, they can be used with close follow-up in patients with a history of failure who are well compensated, and are receiving digitalis and diuretics. Beta-adrenergic blocking agents do not abolish the inotropic action of digitalis on heart muscle.

IN PATIENTS WITHOUT A HISTORY OF HEART FAILURE, continued use of beta blockers can, in some cases, lead to cardiac failure. Therefore, at the first sign or symptom of heart failure, the patient should be digitalized and/or treated with diuretics, and the response observed closely, or propranolol should be discontinued (gradually, if possible).

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction following abrupt discontinuance of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease who are given propranolol for other indications.

**THYROTOXICOSIS** Beta blockade may mask certain clinical signs of hyperthyroidism. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

**MAJOR SURGERY** The necessity or desirability of withdrawal of beta-blocking therapy prior to major surgery is controversial. It should be noted, however, that the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

**Nonallergic Bronchospasm (eg, chronic bronchitis, emphysema)—** PATIENTS WITH BRONCHOSPASTIC DISEASES SHOULD, IN GENERAL, NOT RECEIVE BETA BLOCKERS. Inderal should be administered with caution, since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

**DIABETES AND HYPOGLYCEMIA** Beta-adrenergic blockade may prevent the appearance of certain premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia in labile insulin-dependent diabetes. In these patients, it may be more difficult to adjust the dosage of insulin. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

**Hydrochlorothiazide:** Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic-blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

## PRECAUTIONS

**Propranolol hydrochloride (INDERAL® LA):** GENERAL Propranolol should be used with caution in patients with impaired hepatic or renal function. Propranolol is not indicated for the treatment of hypertensive emergencies.

Beta-adrenoreceptor blockade can cause reduction of intraocular pressure. Patients should be told that propranolol may interfere with the glaucoma screening test. Withdrawal may lead to a return of increased intraocular pressure.

**CLINICAL LABORATORY TESTS** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

**DRUG INTERACTIONS** Patients receiving catecholamine-depleting drugs, such as reserpine, should be closely observed if propranolol is administered. The added catecholamine-blocking action may produce an excessive reduction of resting sympathetic nervous activity, which may result in hypotension, marked bradycardia, vertigo, syncope, attacks, or orthostatic hypotension.

**CARCINOGENESIS, MUTAGENESIS, IMPAIRMENT OF FERTILITY** Long-term studies in animals have been conducted to evaluate toxic effects and carcinogenic potential. In 18-month studies, in both rats and mice, employing doses up to 150 mg/kg/day, there was no evidence of significant drug-induced toxicity. There were no drug-related tumorigenic effects at any of the dosage levels. Reproductive studies in animals did not show any impairment of fertility that was attributable to the drug.

**PREGNANCY** Pregnancy Category C. Propranolol has been shown to be embryotoxic in animal studies at doses about 10 times greater than the maximal recommended human dose. There are no adequate and well-controlled studies in pregnant women. Propranolol should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

**NURSING MOTHERS** Propranolol is excreted in human milk. Caution should be exercised when propranolol is administered to a nursing mother.

**PEDIATRIC USE:** Safety and effectiveness in children have not been established.

**Hydrochlorothiazide:** GENERAL Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs irrespective of cause are: Dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effect of digitalis (eg, increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements, such as foods with a high potassium content.

Any chloride deficit is generally mild and usually does not require specific treatment, except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism, such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

**DRUG INTERACTIONS** Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of thiazides may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

**PREGNANCY** Pregnancy Category C. Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnancy requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

**NURSING MOTHERS** Thiazides appear in human milk. If use of the drug is deemed essential, the patient should stop nursing.

**PEDIATRIC USE:** Safety and effectiveness in children have not been established.

## ADVERSE REACTIONS

**Propranolol hydrochloride (INDERAL® LA):** Most adverse effects have been mild and transient and have rarely required the withdrawal of therapy.

**Cardiovascular:** Bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands; thrombocytopenic purpura, arterial insufficiency, usually of the Raynaud type.

**Central Nervous System:** Lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short-term memory loss, emotional lability, slightly clouded sensorium; and decreased performance on neuropsychometrics.

**Gastrointestinal:** Nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

**Allergic:** Pharyngitis and agranulocytosis, erythematous rash; fever combined with aching and sore throat; laryngospasm and respiratory distress.

**Respiratory:** Bronchospasm.

**Hematologic:** Agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

**Auto-immune:** In extremely rare instances, systemic lupus erythematosus has been reported.

**Miscellaneous:** Alopecia, LE-like reactions, psoriasiform rashes; dry eyes, male impotence, and Peyronie's disease have been reported rarely. Oculomucocutaneous reactions involving the skin, serous membranes, and conjunctivae reported for a beta blocker (practolol) have not been associated with propranolol.

## Hydrochlorothiazide:

**Gastrointestinal:** Anorexia; gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice); pancreatitis, sialadenitis.

**Central Nervous System:** Dizziness, vertigo, paresthesias, headache, xanthopsia.

**Hematologic:** Leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

**Cardiovascular:** Orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

**Hypersensitivity:** Purpura, photosensitivity, rash, urticaria; necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress, including pneumonitis, anaphylactic reactions.

**Other:** Hyperglycemia, glycosuria, hyperuricemia, muscle spasm; weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

\* The appearance of these capsules is a registered trademark of Ayerst Laboratories.

## REFERENCE:

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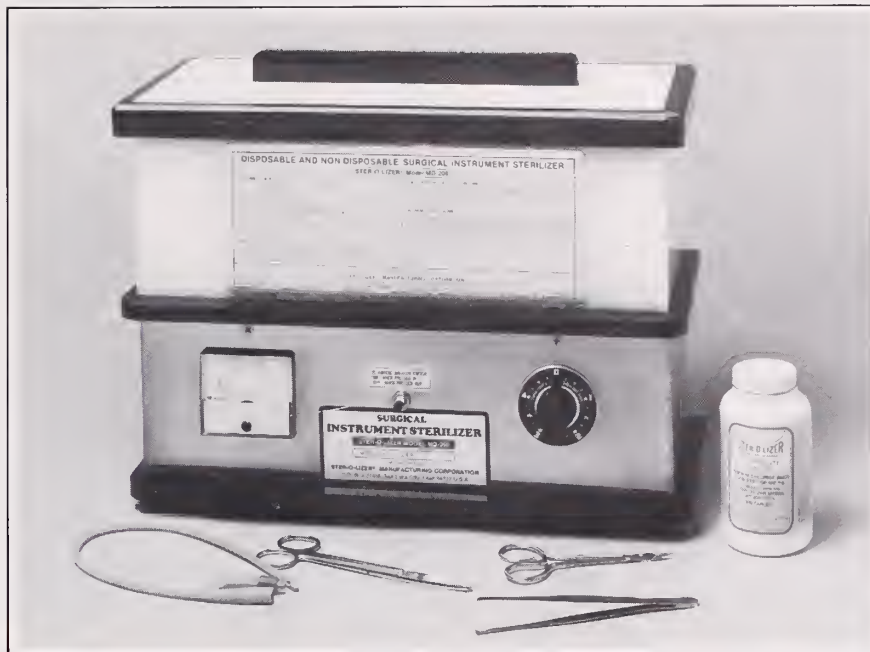
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## Dear Santa Claus

I hope you will forgive me for this letter. I know you are in the business of making toys and driving reindeer and maybe you can't manage to bring me any of the presents on my list.

I will never forget that really wonderful present you brought us about twenty years ago. If you remember, it was called "Medicare," and it came in a big shiny barrel wrapped in sterling silver foil and tied with ribbons dyed in red ink. It was such a neat gift! Inside the barrel there were billions of goodies. You wouldn't believe how many bureaucrats and insurance salesmen and politicians and demagogues have dipped into that barrel and found out that you *had* answered their letters.

As you can see, my list is sort of related to that gift you called "Medicare." Over the years, we've had more and more problems trying to make it work. We've read all the instructions that came with it, but we still can't make it work. Several years ago we decided we hadn't put it together right so we've taken it apart and tried to put it back together at least a dozen times. Nothing seems to be right and we sure do need to fix it.

Finally, I figured out we need some parts that didn't come with the present. Maybe one of your elves just forgot to put them in the barrel. Anyway, however it happened, here is my list of things I want for Christmas. Maybe some of them will fix the barrel for a while and keep it from coming to staves. I sure hope you can bring me at least a few of these things. I promise to be real good all year long. I want . . .

A means test for graduated Medicare eligibility  
 A concise, comprehensive definition of "health care"  
 A fair and rational reimbursement schedule that will encourage physicians to talk to their patients  
 An honest, factual determination of the direct and indirect, non-care, administrative overhead costs of Medicare.  
 A test of the constitutionality of all Medicare rules and regulations  
 The reinstatement of the physician's right to contract with his patients  
 The reinstatement of the physician's right to determine the value of his services  
 One or two genuine "peers" to evaluate my performance as a physician  
 My right to face my accusers, know their credentials, challenge their competency, and enjoy the protection of due process any time my professional judgment is abrogated

Well, Santa, thanks a lot for reading my letter. It would be real nice if you could bring me all these presents, but I will understand if you can't. I won't quit believing in you. Ever since Medicare, *everyone* believes in you.

Lots and lots of love.

—MRJ

P.S. Oh yes, I forgot to mention. I would also like to have a bottom for the barrel.

**D**ear Fellow Physicians:  
Each of us is constantly bombarded by regulations, parameters, and restrictions in the treatment of our patients.

However, we must not lose sight of our moral and ethical responsibilities, ie, to treat each individual patient in an intelligent and humane fashion in spite of the attempts by third parties to regulate what we do.

The government is, of course, an obvious interloper in the way we may feel a sick person should be treated. However, our own hospitals, and even more frequently, the private insurance companies, often attempt to tell us what to do and how to do it, with the obvious goal of limiting treatment and saving dollars.

We physicians must stand firm against these actions and do what we feel is right. Our physician Board of Directors of the Oklahoma Foundation for Peer Review (OFPR) assures me that good, intelli-

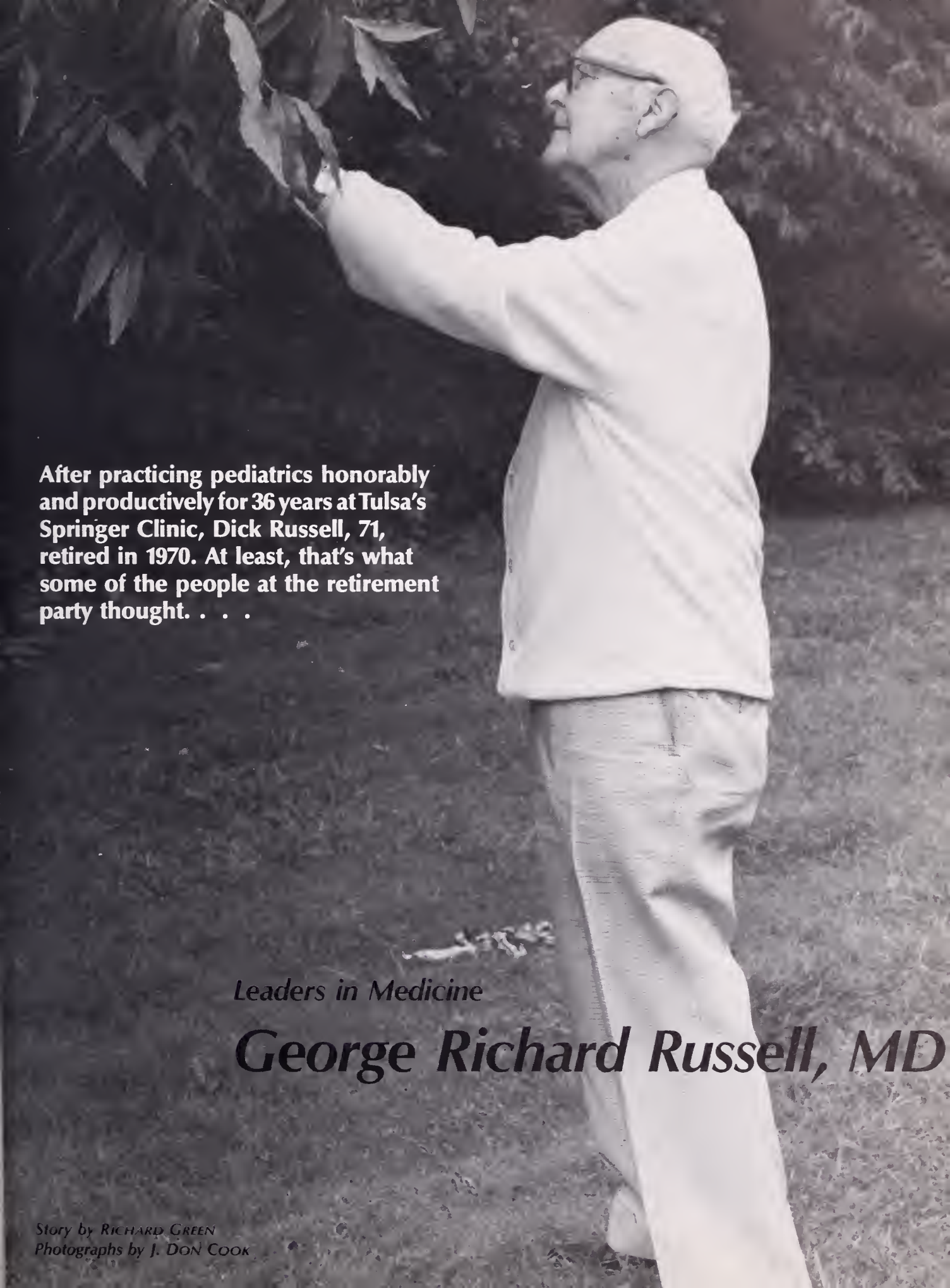


gent medical practice will prevent any government sanctions of significance as long as the physicians in Oklahoma have some degree of control of this peer review organization. Insurance companies, however, are usually outside of the influence of physicians; nonetheless, we must not let them dictate the mode of treatment that we might choose, particularly if we feel that their wishes are detrimental to the patient's well-being.

Remember, you the doctor are well trained, intelligent, and caring; you are probably the only person providing care who is totally committed to that individual's health. It is imperative that your patient be treated the way you think is right.

A handwritten signature in dark ink that reads "Norman L. Dunitz, MD." The signature is written in a cursive, flowing style.

Norman L. Dunitz, MD



After practicing pediatrics honorably and productively for 36 years at Tulsa's Springer Clinic, Dick Russell, 71, retired in 1970. At least, that's what some of the people at the retirement party thought. . . .

*Leaders in Medicine*

***George Richard Russell, MD***

Story by RICHARD GREEN  
Photographs by J. DON COOK

...But scarcely before the cake's candles and the testimonials had died down, Russell volunteered to work in a small clinic serving Tulsa's impoverished black population. The Northside Moton Center (as it was called) was staffed by one other full-time doctor.

When he "retired" as its medical director at the age of 80 in 1979, the small clinic had been transformed into a much larger, more comprehensive facility called the Moton Health Center. There were eight full-time physicians, numerous auxiliaries, OU medical residents, and medical students. The center had just added another building, a \$1 million, 8,500-square-foot structure called the George Richard Russell Pediatrics Building.

Even more significant to Russell was the achievement of his primary goal: diminishing the area's huge infant mortality rate. Based on a study he had conducted, Russell estimated that Moton's service area had an infant mortality rate of 68 per 1,000 in 1970. That meant 68 babies in that area would die before their first birthday, compared to 21 per thousand babies statewide.

When Russell left Moton nine years later, the rate was 11, lower than Oklahoma's rate of nearly 13.

Though many factors combined to reduce the infant mortality rate, Russell's leadership at Moton made the dramatic reduction possible. And this, probably the paramount achievement in a medical career that spanned over a half century, began when he was six years over retirement age and continued throughout his seventies.

Events and fate combined, and Russell, who always had been a planner and builder and still had plenty of enthusiasm and energy, took it from there.

\* \* \*

George Richard Russell was born in Hamler, Ohio, population 596, in 1899. William McKinley was president, and \$1,000 a year was a "damned good wage." His father, Arthur, was a country doctor who was descended from three generations of physicians.

Dick, as the boy was called, occasionally accompanied his father on his house calls around Napoleon, Ohio, where the family had settled. "Once, I saw him save a life by removing an appendix on a kitchen table," Dick recalls.

Such heroics were exceptional, however, among doctors in the early twentieth century. The doctor's bag contained only a few items: a stethoscope, syringes, and some bottles and ampules. About the

only important drug the country doctor carried was morphine.

Patients got better, without much or any help from the doctors of those days. However, most of those who survived their illnesses believed the doctor had saved them, even though he offered scarcely more than his presence and an array of natural formulations that were almost as mystical to the doctor as to the patient.

What a good doctor, such as Arthur Russell, *could* do was make an accurate diagnosis and consequently provide a reliable prognosis. This knowledge, and the skill with which it was dispensed, impressed Dick. These observations became a legacy after Dr Russell's sudden death when Dick was 15 and his brother was 5.

Their mother, Sarah, was from Napoleon. Her father, reputed to be the first engineering graduate at Michigan State University, came to the town and designed the courthouse and cemetery. In a bizarre twist of fate, he died from pneumonia at age 32 and was the first person buried in the new cemetery.

Though Sarah was a school teacher before her marriage, she didn't return to teaching after Arthur's death. Rather, Sarah and Dick took over the local telephone company, her late husband's other business. "My mother did the collecting and I did the hiring and firing and handled the account books," Russell says.

The operation proceeded smoothly until World War I, when some "patriotic" telephone customers told Dick that he shouldn't allow certain ethnic groups to converse in German. All phone lines then were party lines. Dick refused, saying he didn't believe there were any Teutonic spies in Napoleon.

About that time, he took a six-week education course and became a teacher in the town's one-room school house. He had 35 students, first through eighth graders. During that year, 1917, he applied to the US Naval Academy in Annapolis, Maryland. Because of 20/220 vision in his left eye, his application was rejected.

Consequently, he matriculated at Ohio's Defiance College and joined the students' army training corps. Russell was inducted the following year, but the armistice was signed before he could ship out.

Russell entered the state's best pre-med program at Western Reserve University in Cleveland. He earned his bachelor's degree following his first year in the university's medical school. He was graduated



## Physical fitness is important to Russell, who has no intention of slowing down.

said, 'Hell, Russell, you'd never have enough patients to stick in your ear.'"

Although his chief's sentiment wasn't convincing, it did have the ring of authority, which was the overriding factor in those days. As a pediatric resident the following year, Russell admitted the first patient to Cleveland's new teaching facility, Babies and Childrens Hospital.

His pediatric residency included one year of studying contagion, as infectious diseases were called. "There were 1,700 cases of diphtheria that year," Russell says. "And at any one time, there'd be 25 of these kids with breathing tubes down their throats to bypass the obstruction formed by inflamed membranes."

Russell remembers one of those 1,700 kids particularly well. "When this little Italian boy was admitted, he was nearly black from strangulation. He was accompanied by his family and a priest. I couldn't get a breathing tube down his throat, so I did an emergency tracheostomy, and the boy almost immediately turned pink. The nurse on the case was so impressed that she later became my wife, Pauline."

The year 1929 was notable for another reason. The family decided to sell the phone company, and Sarah wanted to use the money, about \$100,000, to buy stock in AT&T. Dick persuaded her in the fall of that year to change her mind. A few days later the stock market crashed, which would have wiped out the family's fortune. Later, the family bought AT&T stock for a fraction of its precrash cost.

in 1925 and interned at Cleveland's University Hospital.

"I decided to be a pediatric surgeon," Russell says. "There were only a couple in the whole country but one was at Western Reserve. Well, my pediatric chief



**"If I could survive 14  
more years, I will have lived  
in three different centuries.  
Wouldn't that be something?"**

In 1930, the pediatrics chief rewarded Russell with a year's sabbatical in Marburg, Germany. He became involved in a research project and discovered a bacterial inhibitory substance in the duodenal part of the intestine. He described the project in a paper later published in one of Germany's leading medical journals. In the paper, he made up a name—something like bacteria zadine—for the mystery substance, but the name didn't stick. Someone else would call it gamma globulin.

Before returning to Cleveland, Russell toured Europe. He attended the first international Congress of Pediatrics in Stockholm, read a newspaper outside at midnight in Norway, detected no unnatural movement within Loch Ness, stayed appropriately at London's Russell Square, and ate in the Munich beer hall where Hitler staged his first grab for power in 1923. "Most of the Germans I talked to said the country would never return to power," Russell remembers.

Russell was an associate professor of pediatrics at Western Reserve in 1932. By training, experience, and talent, he was achieving excellence as an academic physician. Still, he was uneasy. "I just didn't feel I was cut out to be a professor."

Meanwhile, a former medical student of Russell's had come to the same conclusion. Dr Homer Ruprecht called Russell and told him there was an opening for a pediatrician at the clinic where he was working, in Tulsa. Russell recalls, "I thought, 'my God, that's Indian country,' but Ruprecht convinced me to come down for a looksee. The clinic had five or six doctors."

In April 1933, Russell arrived at Tulsa's train depot and was amazed by what he saw. "Everything in Tulsa was bright and new and clean and the people were enthusiastic. All the buildings in Cleveland had turned black from the dirt and smoke. It wasn't a hard decision at all."

\* \* \*

The doctor who had preceded Russell at the Springer Clinic had taken most of his patients and all of the charts with him. So Russell started from scratch during America's Great Depression. From April through December, he generated \$429. Since he was being paid \$250 a month, the clinic's bookkeeper, a certain Mr Tucker, took a dim view of the new man's prospects.

"Tucker hated Dick," Ruprecht says. "He told me more than once that Dick wasn't going to make it.



And I told him (more than once) that his opinion was absurd. Dick's training was superb; he was easily the best-trained pediatrician in the state. And he had a good personality. Actually, none of us were doing too well then."

During the Depression years, Russell's practice grew steadily. Then, in 1938, Dr Springer told his physicians that he "wanted to go fishing," and suggested that they form a partnership. "We divided it up on the basis that all branches of medicine are equal," Russell says.

By 1940, Russell was the clinic's top revenue producer, a fact he is still proud to mention. A year later, he was almost the only producer. During World War II, Russell was one of only three pediatricians in Tulsa. He saw patients in his own exam rooms and in those of his departed colleagues. "It was unreal," he says. "I was seeing 70 to 80 patients a day, making some house calls, making rounds at Saint John Hospital, and taking an average of 30 telephone calls. I slept six hours and worked all the rest."

Russell says that while he didn't much like the pace and hours, particularly since he and Pauline had three young sons, he believed that this was his contribution to the war effort. "It was an emergency and I acted accordingly."

The advent of antibiotics changed the practice of medicine forever. Before the medicines, little could be done to alter the course of most of the illnesses, Russell recalls. "But the first time I used a sulfa drug on a bad case of otitis media, the infection was stopped almost immediately. I thought, 'For chris-sake, this is a miracle.'"

The next miracle would come in the early 1950s. At the American Academy of Pediatrics annual



meeting in Miami, Russell heard Dr Jonas Salk describe his new polio vaccine. "It was a sensation, for sure, particularly for many of us who were used to dealing with lots of polio cases.

"I was in charge of the polio ward at Saint John. We had 30 or 40 beds and four iron lungs. When they'd bring in a young child, the nurses would wrap him in hot packs and that probably kept the paralysis down some, but we were pretty helpless."

Most of his patients, however, just had normal childhood illnesses, which was the way Russell liked it. His pitch to the parents was a detailed health supervision program that they could apply to maintain their children's good health. His friend and colleague, internist Homer Ruprecht, says he never could understand how Russell, with his superior training and experience, could be content to see

legions of normal kids troop through his office every day.

Russell says he was delighted to see normal, essentially healthy children grow up. "He had a great way with children," says Tulsan Jack Spears. "Dick was very gentle and positive. And he showed concern not only for his patients but also for their often anxious parents. I was one of those parents."

Spears, then director of the Tulsa County Medical Society, and Russell also had a professional relationship. Russell served on the society's board of trustees for years and in 1957 was elected president. The next year he served as Saint John's chief of staff and served on the hospital's board of governors until 1966.

**B**y the late 1950s, the Springer Clinic had expanded all it could in its original building in downtown Tulsa. Russell for years had been talking up interest in changing locations, and in the early 1960s all the partners agreed to move. "We got a good price on some land at 41st and Yale, but a large shopping center was going in there, and I didn't want to wind up with a shopping center clinic. I wanted to be affiliated with a medical center."

At that point, Russell got a call from William K. Warren, a prominent Tulsa oilman-philanthropist. "He wanted us to relocate out by Saint Francis Hospital, which the Warren Foundation had built at 61st and Yale in 1960. Back then, that was a long way out, at least psychologically. Warren told me business had been slow since the hospital opened, and they needed our clinic out there."

According to Russell, Warren offered "to build the clinic to our specifications on Warren-owned land adjacent to the hospital and then sell it back to us." So, in 1963, the Springer Clinic moved to its present location.

It was a mutually beneficial arrangement. Four months after the clinic opened, Saint Francis was breaking even, and the clinic's partners had a first-rate facility, which they bought from the Warren Foundation in 1964.

That year, Dick Russell turned 65, the clinic's traditional retirement age. However, if a partner wanted to continue practicing, he could petition his colleagues for a one-year extension on an annual basis. Russell didn't consider retirement long enough to even be repelled by the idea. Though the clinic had five to seven times the original number of doctors, Russell was still germinating many new plans and ideas for the group.

Ruprecht says Dick always was “a builder. He was an excellent pediatrician, but he also would have made one helluva business executive.”

By the late 1960s, Russell was ready for something new. Perhaps it was a mid-life crisis, delayed by 20 years. Or maybe he didn't feel as much a part of the clinic's operation with some of his current partners having been babies when he started at Springer.

In any case, Russell became interested in a new project around 1970. He had conducted an infant mortality study in Tulsa's black community and had been appalled to find that its rate was more than three times higher than Oklahoma's rate and probably several times higher than the rate among white Tulsans.

The year before, Tulsa's city-county health department and the local medical society had

combined to sponsor the Northside Moton Center, an indigent-care clinic. Russell contacted Dr George Prothro, then city-county health director, and volunteered to work at Moton. “Dr Russell was very energetic and enthusiastic about what he'd like to do at Moton, and we were very happy to help him,” says Prothro, now a clinical professor of family practice at the University of Oklahoma's Tulsa Medical College.

Initially, Russell saw patients and their parents, one of whom he remembers well. “A black lady came in and told me that her 16-year-old daughter was fooling around with an older boy, who had a car. She said she was too young to be a grandmother and needed help. I said I'd visit with a local obstetrician and get back to her.”

Russell went to see a local obstetrician and relayed the woman's story, in part, to try to enlist his



**Dick gives his wife Reba, a nutritionist, much of the credit for his good health.**



help in establishing an adolescent clinic. The obstetrician responded to the mother's story with this prescription: "I'd whip that girl's butt." Russell hastily bade the man a good day.

Within a year, Prothro chose Russell to be Moton's medical director, and with new federal funding, the way was clear to expand the medical staff and begin an adolescent clinic that would offer sex education and contraceptives (with parental permission) and a prenatal clinic.

Because Moton's new teen offerings were advertised at all northside schools, the clinics were well attended and played a substantial role in reducing the area's infant mortality rate. "On the one hand, we taught pregnancy prevention," Russell

says. "And on the other hand, we provided good comprehensive prenatal care — as good as any in Tulsa."

The Tulsa County Medical Society honored Dick Russell as its "Doctor of the Year" in 1973. And when OU's Tulsa Medical College got underway, Russell was named clinical professor of pediatrics and soon had medical students and residents involved at Moton. During the height of federal funding, Russell had 12 physicians working full-time at Moton. The Moton Health Center was the only facility of its kind in the state to be accredited by the Joint Commission for Accreditation of Hospitals and Ambulatory Care Centers.

By 1979, the infant mortality rate had been reduced to about 12 per thousand, less than the state's rate. But the number of full-time doctors was down to eight. Russell says that misunderstandings with Moton's new administrator were to blame for the reduction and for his own "premature retirement" that December.

Moton's new pediatric building was dedicated in Russell's name before he left, but not before Pauline's death in May. She had been a diabetic for years and had died from congestive heart failure.

Later Russell met and married a PhD in nutrition. "I met Reba playing bridge, and we've been having fun ever since. We've been all over the world in the last six years and we ain't done yet. Do you know that when I was born in 1899, the life expectancy was 42? I've more than doubled that. If I could survive 14 more years, I will have lived in three different centuries. Wouldn't that be something?"

It would be Dick Russell's last big accomplishment; nothing, really, compared to his others. ¶

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# Recombinant DNA and the Physician

FREDERICK V. SCHAEFER, PhD; BURHAN SAY, MD

**Recombinant DNA analysis is able to identify genetic diseases and inheritance patterns impossible to detect by any other tests and, like cytogenetic analysis, will become a standard diagnostic tool.**

The discovery of the structure of deoxyribonucleic acid (DNA) 32 years ago started a revolution in biomedical research. Today the practicing physician is confronted with such terms as *genetic engineering*, *recombinant DNA*, and *gene therapy*. It has been shown that newly discovered biomedical techniques can identify and describe the etiologies for an increasing number of genetic diseases. They are rapidly becoming important diagnostic tools. The purpose of this presentation is to briefly describe current biomedical research of clinical significance and discuss the current and future applications with an emphasis on recombinant DNA technology and DNA probes.

Recombinant DNA indicates the joining or recombining of two or more pieces of DNA. For the purpose of clinical diagnosis, at least one of the two pieces is obtained from human DNA. Recombinant DNA can identify alterations in the chromosome ranging from deletions and translocations to single-point mutations. However, as with all new technologies, there are limitations that must be understood to apply properly the techniques and interpret the results.

## What Are Recombinant DNA Probes?

A recombinant DNA probe is commonly composed of a segment of human genomic DNA integrated into the DNA of a vector and a detection system. The genomic material or insert confers the specificity of the probe through a complementary sequence in the DNA of chromosomes. The vector is a carrier, such as a plasmid or bacteriophage, which contains the controls by which it can self-replicate in bacteria. As the vector is duplicated, many copies of the integrated genomic DNA are also generated. Technical limitations dictate which vector is used. Genomic DNA inserted into plasmids is generally limited to sizes between 100 and 7,000 nucleotide bases; DNA incorporated into bacteriophages ranges between 5,000 and 15,000 bases.<sup>1</sup>

Although genomic material in plasmid or bacteriophage recombinant DNA can be made to bind the complementary sequences in sample DNA, the interaction cannot be detected unless the recombinant structure also contains the means by which the interaction can be visualized. The addition of a detection system allows the plasmid or bacteriophage to be a probe, ie, a tool to detect or probe for complementary sequences in a patient's DNA.

Traditionally, the probes are made radioactive by incorporating radioactive nucleotides into the DNA sequences. The probes will bind or hybridize with unknown DNA under conditions where only long complementary base sequences can adhere to one another. Fortuitous hybridization of short sequences

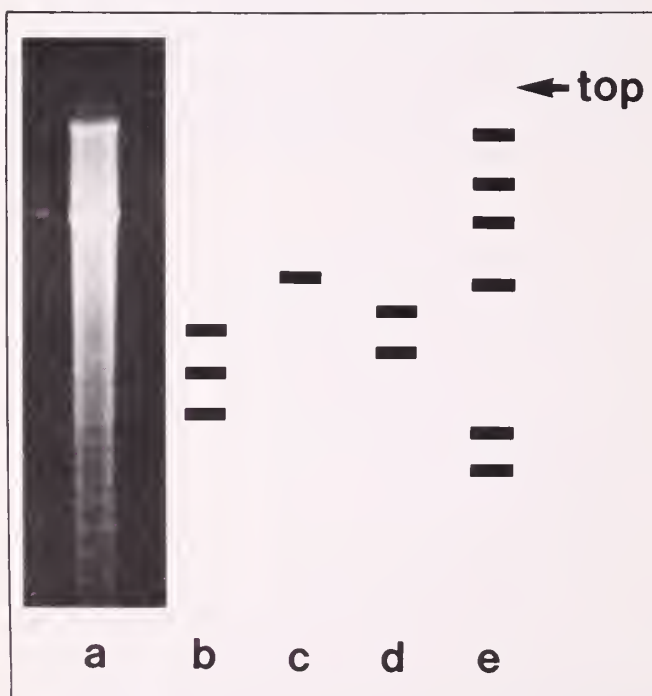
From the H.A. Chapman Research Institute of Medical Genetics, Children's Medical Center, 5300 E. Skelly Drive, Tulsa, OK 74135.

and unbound probes are then washed away and the firmly bound probes visualized by exposure to x-ray film (Fig 1).

Recently the components of a sensitive staining system have been incorporated into DNA probes. The resulting positive reactions may appear as brown stains or fluorescent spots depending on the system used.<sup>2</sup> The latter method eliminates the need to work with radioactive isotopes. However, the process is not yet as sensitive as the isotope techniques.

In addition, it has become possible to build DNA probes in the laboratory. Sequences of 10 to 100 bases are constructed chemically using a DNA synthesizer.<sup>3</sup> Subsequently, the DNA fragments are made radioactive and used as probes. This approach can be especially advantageous when a great deal is known about the defect causing a specific disease.

The sensitivity of either approach ultimately depends on the genomic sequences binding *only* the appropriate complementary sequences in the test



**Figure 1.** DNA polymorphisms to a gene probe. Human DNA has been cut with a restriction enzyme into many individual bands and separated by electrophoresis by size. The complexity of human DNA results in unresolved, overlapping bands and appears as a smear (a). From a random population of 20 people, 3 may hybridize differently to the same gene probe. This results in different patterns of bands which can be visualized by exposure to x-ray film and is illustrated here schematically (b, c, d). The sizes of the DNA fragments are determined by comparison to a restriction enzyme digested lambda bacteriophage standard (e) ranging from 23,500 bases (top) to 2,000 bases (bottom).

## Glossary

**Bacteriophage** — a virus which can infect bacteria.

**Hybridization** — the process by which complementary nucleotide sequences are allowed to bind to one another. The conditions of this reaction can be adjusted to change the number of perfectly complementary bases required for the reaction to be stable.

**Nucleotide bases** — the four building blocks of DNA: A, adenine; G, guanine; C, cytosine; T, thymidine. The human genome is composed of over  $2 \times 10^8$  nucleotides.

**Plasmid** — a small circular piece of DNA which can replicate autonomously in a bacterium.

**Probe** — a small DNA fragment which can be used to locate complementary DNA sequences.

**Recombinant DNA** — a constructed molecule composed of DNA derived from two or more sources.

**Restriction enzyme** — a protein which will cut DNA at a specific nucleotide sequence.

DNA. A typical probe containing a sequence 200 to 2,000 bases long will only bind a complementary sequence that is virtually unique. For example, if the DNA from a patient with beta thalassemia does not react with a probe with a 500-base genomic insert for beta globin chain, the deletion of all or most of the beta globin chain gene is likely and probably accounts for the patient's condition. The size of the probe precludes the reaction of the probe to the DNA of similar proteins, such as the alpha or gamma globin chains. However, limited areas of uncomplementary bases will be tolerated by large probes.

In the example of sickle cell anemia, this same beta globin chain gene probe would be uninformative. A single-point mutation of A to T would not destabilize the hybridization of this probe to a sickle cell patient's DNA enough to prevent binding of the DNAs. Therefore, both an unaffected individual and a patient with sickle cell anemia would have the same reaction with this probe.

Genetic diseases that result from mutation of a single base in their sequence can be detected with smaller probes. Chemically synthesized oligonucleotide probes 10 to 20 bases long will be destabilized by a single inappropriate nucleotide simply because a single base constitutes a significant portion of a very small probe. Therefore, diseases with a known sequence alteration, such as sickle cell anemia, can be easily identified. However, with synthesized probes there may be identical sequences elsewhere in the genome that will compete for this probe. A probe of 12 bases cannot be as unique as one 500 bases long. Also, defects only 10 bases away may remain undetected as a result of the small size of the probe.

With either a large or small probe, the portion of

the genome that can be surveyed is restricted to the size of the insert. To fully evaluate the human genome, 100,000 contiguous and defined probes of 2,000 bases each would be required. Obviously a less laborious way of examining large sections of the genome is required. One such technique is the use of restriction fragment length polymorphisms (RFLPs).

### Restriction Fragment Length Polymorphisms (RFLPs)

Properly functioning genes require a precise sequence of 4 DNA bases. Mutations, deletions, or translocations all result in an alteration in the appropriate sequence of nucleotide bases in DNA. Restriction enzymes are proteins that cleave DNA at a single site within a specific sequence of bases. For example, the restriction enzyme Eco R1 recognizes the 6-base sequence GAATTC and cleaves the DNA between the G and A bases each time this sequence occurs. If DNA were entirely random, such a 6-base sequence would occur every 4,100 bases, and many fragments of this length would result. Any alteration in this 6-base sequence at one site would prevent the cleavage of 2 of the fragments and would result in a large fragment of 8,200 bases. Similarly, a sequence change that creates such 6-base sequences where none previously existed would result in 2 fragments smaller than 4,100 bases. The fragments can then be separated by electrophoresis on the basis of size.

To learn the size of the fragment on which a gene resides and detect any changes in the size of the fragment, a radioactive probe is used to localize the gene. Obviously, a major advantage of the approach is that the probe can detect changes in its resident fragment but does not actually have to span the altered bases. Consequently, much larger sections of DNA can be surveyed. The principal disadvantage is equally apparent. Since the DNA must be cleaved by restriction enzymes, only an alteration in that specific 6-base sequence is detected. This would be especially critical in the case of small alterations, for example, single-base mutations. In the case of sickle cell anemia we are fortunate to find Mst II no longer cleaves the DNA at the altered loci of beta globin.<sup>2</sup> Most other restriction enzymes will not detect the change and are uninformative.

Gross deletions or translocations are more easily detected. Generally, the use of several different restriction enzymes enhances the odds of finding an informative change in the sequence. Theoretically, the existence of only 400 ideal probes would be re-

Table 1. — Status of Probes to Common Genetic Diseases\*

Genetic Disease	Incidence <sup>5</sup> in Population	Carrier Frequency	Clone Availability
Sickle-cell anemia <sup>2</sup>	1 in 625	1 in 12	now
Phenylketonuria <sup>6</sup>	1 in 12,000	1 in 50	now
Hemophilia <sup>7</sup>	1 in 10,000	1 in 5,000	now
Duchenne muscular dystrophy <sup>8</sup>	1 in 7,000	1 in 5,000	now
Huntington's disease	1 in 2,500	1 in 2,500	2 yr <sup>†</sup>
Cystic fibrosis	1 in 2,000	1 in 22	now

\*Many more probes exist to diseases of lower incidence and to restricted classes of a family of related diseases.  
<sup>†</sup>Projected date.

quired to detect an alteration anywhere in the human chromosomes. In reality, at least 1,000 will be required. Several laboratories and commercial firms are rapidly developing such a panel, which may be available in a year or two.

### RFLPs in the Human Genome

RFLP analysis of randomly selected normal individuals often reveals a great variability in the sizes of the fragments on which the identical genes reside (Fig 1). This nonpathogenic variability in human DNA is a result of the fact that there is a mutation about every 200 bases in our DNA. However, the alterations reside in DNA that is not needed to produce or regulate proteins and consequently go unnoticed.

This normal variability, or polymorphism, leads to a significant problem for the clinician wanting to use the RFLP technique for diagnosis of disease. Simply, each family must be examined as a unique entity. Only by examining the parents and one affected child or close relative can a reliable diagnosis be made as to the presence of that genetic defect or disease in the patient or fetus. If such conditions are met, the clinician will soon be able to diagnose any genetic disease and be able to advise the parents.

### Present and Future Clinical Applications

Today we are able to diagnose by RFLP analysis a few genetic diseases for which the appropriate probes and restriction enzymes exist, and more are on the near horizon (Table 1). In the future, with a fuller understanding of normal polymorphism at specific sites, we hope to be able to develop a panel of probes and restriction enzymes for all genetic diseases. Eventually, we may be able to accurately diagnose

RFLP without first examining the patient's relatives. Certainly a moderately detailed gene map of every human chromosome no longer seems to be an unrealistic dream. At the Chapman Institute of Medical Genetics at the Children's Medical Center in Tulsa, we are initiating clinical services using gene probes and recombinant DNA technology to diagnose the diseases listed in Table 1, as well as others as they become adequately defined.

Diagnosis and the understanding of how defects in DNA result in a disease are also the first requirements on the road to gene therapy. Gene therapy will allow the physician to correct a defect in the DNA of the patient's own cells.<sup>4</sup> Sickle cell anemia or phenylketonuria, which have well characterized defects, may be among the first candidates for such therapy. Preliminary clinical trials are being planned to correct Lesch-Nyhan syndrome and selected severe immunodeficiency diseases. However, the ultimate success of gene therapy for most diseases must await a fuller understanding of genes and their regulation.



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# Long-Term Mechanical Ventilation in an Acute Care Hospital: A Positive Approach

Raymond J. Dougherty, MD; Jeffrey L. Neff, RRT; Karen S. Thornton, RRT

**Historically, patients requiring continuous mechanical ventilation have been cared for primarily in critical care units. With thorough planning, they can be maintained on a general medical floor, allowing greater access to the ICU by more acutely ill patients.**

This report describes implementation of long-term mechanical ventilation (LTMV) on patients hospitalized on a no-smoking general medical floor. This arrangement was designed to (1) open the intensive care space to more acute medical emergencies, (2) foster a better environment for patient-family interaction, and (3) provide an environment for LTMV on those patients in which a short-term resolution of the respiratory failure is not evident and long-term hospitalization was likely.

In acute care hospitals, the availability of intensive care unit (ICU) beds is sometimes a problem. When this occurs, attention tends to focus on patients who are on long-term mechanical ventilation (LTMV). These patients interfere with the even flow of patients in and out of the ICU, the scheduling of surgery, the optimum use of the emergency room, and the accommodation of patients who develop catastrophic events while in the general hospital. The personnel in ICU are geared to provide acute intensive care and may be frustrated by the long-term care of fairly stable patients on LTMV whose progress towards recovery has been very slow or absent.

Cursory consideration of these patients may result in the emerging of a false impression of an elderly, hopelessly ill man who is responsible for his own plight by excessive smoking. The physician caring for this "old lung" may seem unwilling or inept at forcing the patient off of the ventilator so that he can be transferred to general hospital care, making space for a patient with a better prognosis. Physicians treating these patients may be reluctant to transfer them if there is hope of recovery, since mechanical ventilation has traditionally been considered a reason for keeping a patient in the ICU.

This report examines the types of patients who eventually require LTMV (more than 21 days) and a program in which selected patients from this group were managed on a general medical floor. The financial burden to the hospital of these patients who are under the prospective payment program under Medicare has been recognized.<sup>1,2</sup> We did not closely examine this important issue and hence cannot claim any drastic cost savings. Our efforts were directed toward providing an area outside of ICU where patients on LTMV would obtain good care.

## Patients and Methods

The primary location of the study was Saint Anthony Hospital in Oklahoma City. This is an acute care 550-bed hospital with 32 ICU beds. The patients in this study were admitted to the hospital from January 1982 through September 1984. Although 1,020 patients a year require mechanical ventilation, an

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average of 25 patients per year require LTMV (Graph). In the ICU these patients were maintained either on Puritan-Bennett MA-1 or Siemens Elema Servo 900C volume ventilators. Patients transferred to the general hospital floor were maintained on either MA-1 or LP-5 (Life Products) volume ventilators. Assist-control<sup>3</sup> (AC: preset volume and rate) was the primary mode of ventilation. Attempts at weaning were with intermittent heated nebulization with a T-piece,<sup>3</sup> flow-by through a Siemens ventilator, and synchronized intermittent mandatory ventilation (SIMV).<sup>4</sup> One patient was maintained on a Cuirass ventilator (Life Care 170C)<sup>5</sup> after extubation. Attempts at weaning by more than one method were common. Positive-end expiratory pressure (PEEP)<sup>6</sup> and continuous positive airway pressure (CPAP)<sup>7</sup> were used in some patients to improve oxygenation.

Nearly all of the patients on LTMV had, as either the primary or consulting physician, a pulmonologist who was generally or specifically responsible for the ventilator management and the weaning procedures.

Ten East Central Tower (10ECT) is a no-smoking general medical floor, admitting primarily pulmonary and cardiovascular patients. It has telemetry cardiac monitoring facilities. There is adequate 24-hour special staffing by respiratory therapists and nurses. Nurses were educated by rotation in the ICU. Criteria for admitting patients on LTMV to 10ECT were as follows: (1) physician orders, (2) patient and family approval, (3) medically stable condition, (4) private room, and (5) continuous mechanical ventilation.

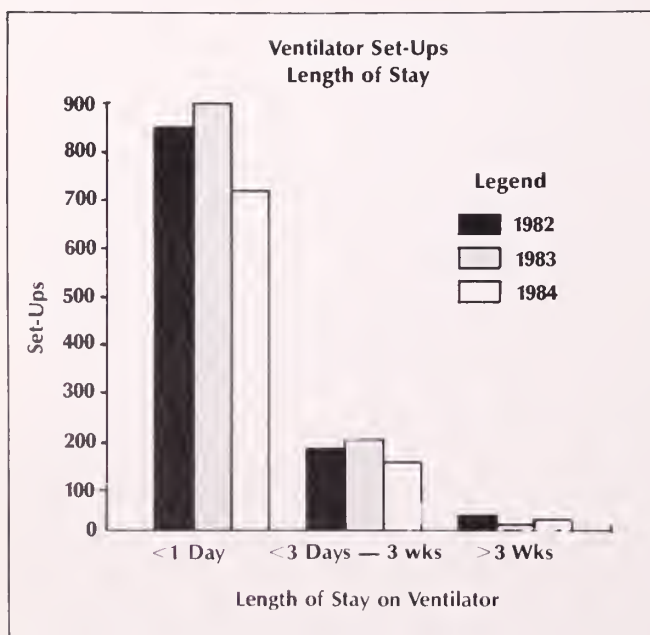


Table. 1 — Admitting Characteristics of LTMV Patients

Place of LTMV Implementation	Number
Other hospitals	10
St Anthony emergency room	6
St Anthony postoperative	30
St Anthony other respiratory failure	31
Total	77
<b>Primary Admitting Diagnoses</b>	
Diagnostic Category	Number
Cardiovascular	10
Pulmonary	20
General medical	7
Neurological	21
General surgical	10
Multiple trauma	9
Total	77
<b>Secondary Diagnoses</b>	
Diagnostic Category	Number
Cardiovascular	21
Pulmonary	114
General medical	82
Neurological	17
Multiple fractures	6
Total	240

## Results

Data were collected on 77 patients who required LTMV. Of these, 38 were referred from other hospitals, and in 10 mechanical ventilation was instituted before admission (Table 1). The primary admitting diagnoses were mainly pulmonary and neurological. The secondary diagnoses and complicating factors were mainly pulmonary and general medical. The average number of secondary diagnoses and complicating factors was three per patient.

The length of stay on the ventilator averaged 55 days, with a low of 21 days and a high of 455 days. Seventy-six patients were maintained primarily on AC and only 1 patient was managed entirely by SIMV. Forty-two patients required PEEP.

SIMV was used at some point in attempts at weaning 36 patients. Flow-by with a T-piece was used with 60 patients, and 34 patients were monitored through the Siemens ventilator for some period during attempts at weaning. CPAP was used on 1 patient. No weaning was attempted on 5 patients.

Forty patients were discharged and 37 died (Table 2). Regardless of diagnosis and discharge status, ventilator days in the ICU were constant. Those patients on 10ECT who died had been on the ventilator three times longer than those discharged. One of the patients who was dismissed to return home was on a

Cuirass ventilator, and 1 was on nocturnal ventilation with an LP-5. Two of the patients dismissed were on continuous ventilation; one was transferred to another hospital, and 1 was transferred to a rehabilitation center. The remaining 36 were weaned from mechanical ventilation prior to discharge.

Twelve patients were transferred to 10ECT before dismissal. The average stay in 10ECT was 69 days, for a total of 823 days. Two days was the low and 304 days was the high. Weaning was accomplished for 4 of these patients, all of whom were eventually dismissed. The organization of 10ECT for the care of patients on LTMV was a joint effort by physicians, respiratory therapists, and nurses. Responsibility was clearly defined, and cooperation was excellent. No major problems related to this location of care developed. Patient and family acceptance of the transfers has been positive. Exceptions to the admission criteria have been allowed at the discretion of the respiratory therapy and nursing services and have resulted in the weaning of selected patients without readmission to ICU.

## Discussion

The profile of the patient on LTMV, which developed during our study, was different from what we expected, with only 20 of the 77 patients having a primary diagnosis of pulmonary disease. Also, there was

a high percentage of patients who were postoperative. The prognosis was better than originally expected, with one-half of them being eventually weaned from continuous mechanical ventilation. Our findings were similar to a report by Witek et al<sup>8</sup> on the diag-

**Our goals were  
to define a subset  
of patients that could  
be transferred  
out of ICU.**


nostic categories and outcome of mechanical ventilation in a community hospital. Although occasionally, in the past, patients on LTMV in Saint Anthony Hospital were transferred to a general medical floor, nurses and respiratory therapists were not organized for this type of care. This resulted in reluctance of the staff to accept these patients. Physicians, patients, and families were quick to recognize this reluctance. The successful care of patients on LTMV on 10ECT resulted from careful planning, the setting of priorities, the defining of responsibilities and level of care required for each individual patient, and the

**Table. 2 — Ventilator Days of LTMV Patients Who Eventually Were Dismissed or Died**

<b>A. Dismissed</b>	<b>ICU Days</b>	<b>Days on Ventilator</b>		<b>(Patients)</b>
		<b>(Patients)</b>	<b>10 ECT Days</b>	
Cardiovascular	42	(2)	0	
Pulmonary	193	(7)	11	(1)*
General medical	73	(3)	0	
Neurological	831	(17)	194	(3)*
General surgical	264	(6)	0	
Multiple trauma	317	(5)	0	
<b>Total</b>	<b>1,720</b>	<b>(40)</b>	<b>205</b>	<b>(4)*</b>
<b>B. Died</b>				
Cardiovascular	250	(8)	2	(1)*
Pulmonary	886	(14)	579	(6)*
General medical	98	(4)	0	
Neurological	92	(3)	0	
General surgical	169	(4)	37	(1)*
Multiple trauma	278	(4)	0	(1)*
<b>Total</b>	<b>1,773</b>	<b>(37)</b>	<b>618</b>	<b>(8)*</b>

\*Initially in ICU, then transferred to 10ECT.

cooperation of all concerned. Our goals were unrelated to cost containment, but were to define a subset of patients on LTMV that could be transferred out of ICU, making space for patients requiring more intensive care. The change in the level of nursing care on 10ECT was balanced by larger patient rooms, greater interaction with the family, decreased noise level, and freedom from the awareness that other patients were being resuscitated.

In summary, this study helped to clarify the types of patients on long-term mechanical ventilation and their prognoses. It helped develop a location on a general medical floor where selected patients on LTMV could be managed successfully, making space for patients requiring management in ICU. 

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*Jeffrey L. Neff, RRT, a member of the adjunct faculty at Rose State College, Midwest City, has been certified by the National Board of Respiratory Care. He is also a member of the American Association of Respiratory Therapy and the Oklahoma Society of Respiratory Therapy.*

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## Coming in December . . .

Manuscripts being considered for publication in the December issue of the JOURNAL include a comparison of the antimicrobial susceptibilities of *Pseudomonas aeruginosa* isolates from two hospitals and a local study of radial keratotomy results. Also included is a commentary on pharmaceutical representatives.



# News from the Oklahoma State Department of Health

## Naturally Occurring Fluoride

Tooth decay is one of this nation's greatest health problems in terms of the number of people affected and its persistence. Children are most vulnerable. Years of research and community demonstrations have shown that optimal concentrations of fluoride in drinking water, about one part fluoride per million parts water, is the most effective and least costly public health measure available to prevent tooth decay.

Fluoride, an element found naturally in all water supplies, has been described as nature's way to help prevent dental decay. Some water supplies are fortunate to have the optimum amount, while other water supplies have either more or less than the optimum amount. Water supplies with fluoride levels of less than optimum should be raised to optimum. Water supplies with fluoride levels greater than optimum are not considered to be health hazards but can cause some dental fluorosis if the levels are sufficiently high.

Dental fluorosis can occur during the years of tooth development, from birth to approximately ten years of age. Mild fluorosis may occur with fluoride levels above two parts per million. However, the Surgeon General, along with medical, dental, and public health groups, has concluded that dental fluorosis, while not a desirable condition, is not an adverse health effect and that fluoride levels

as currently found in US drinking water supplies do not constitute a health hazard.

Actually, research has shown several beneficial effects from fluoride concentrations higher than optimal, such as a further reduction in dental decay and a reduction in osteoporosis. However, because of the possibility of dental fluorosis, higher than optimal levels of fluoride in community water supplies are not recommended for general use.

Optimal levels of fluoride should be encouraged for all community water supplies. In fact, the Surgeon General has pointed out that community water fluoridation at optimal levels is the single most important commitment that a community can make to the oral health of its children and to future generations.

### Notice to Physicians

Because Oklahoma's economic condition has caused fiscal restraint in state programs and services, the Rheumatic Fever Prophylaxis Treatment Program must be discontinued. Through this program, county health departments provided oral or injectable penicillin G on a monthly basis to persons with previous rheumatic fever diagnoses.

Your patients will be notified by their county health department that the program has been discontinued. The patients will be instructed to return to their private physician to obtain a prescription to purchase their medication from a local pharmacy.

The Oklahoma State Department of Health regrets that this service must be discontinued.

DISEASE	August 1986	TOTAL TO DATE		
		This Year	Last Year	5 Yr. Avg.
AMEBIASIS	0	6	10	12
CAMPYLOBACTER INFECTIONS	29	190	223	—
ENCEPHALITIS, INFECTIOUS	2	16	24	23
GIARDIA INFECTIONS	22	127	189	—
GONORRHEA (Use ODH Form 228)	1097	8452	8382	10066
HAEMOPHILUS INFLUENZAE				
INVASIVE DISEASE	9	151	147	—
HEPATITIS A	47	240	323	342
HEPATITIS B	25	134	147	179
HEPATITIS, NON-A NON-B	3	40	47	—
HEPATITIS UNSPECIFIED	6	33	60	114
MEASLES (RUBEOLA)	3	39	1	8
MENINGITIS, ASEPTIC	27	73	94	126
MENINGITIS, BACTERIAL				
(non-meningococcal, non H. Influenzae)	12	53	55	42
MENINGOCOCCAL INFECTIONS	2	20	22	25
PERTUSSIS	24	93	149	125
RABIES (Animal)	9	50	83	116
ROCKY MOUNTAIN SPOTTED FEVER	16	76	81	113
RUBELLA	0	0	1	1
SALMONELLA INFECTIONS	70	319	250	293
SHIGELLA INFECTIONS	32	140	180	221
SYPHILIS (Use ODH Form 228)	11	107	134	137
TETANUS	0	1	1	0
TUBERCULOSIS	27	177	172	198
TULAREMIA	0	6	13	20
TYPHOID FEVER	0	1	0	2

Diseases of Low Frequency	Total to Date This Year
ACQUIRED IMMUNE DEFICIENCY SYNDROME	31
BRUCELLOSIS	0
LEGIONNAIRES DISEASE	13
MALARIA	9
REYE SYNDROME	4
TOXIC SHOCK SYNDROME	24

# Always on call.



For over 20 years, C. L. Frates and Company has been recognized as "Insurance Counselors to the Oklahoma State Medical Association." Because of our long-term relationship with OSMA, we understand the priorities and time limitations of the medical profession.

We are deeply committed to meeting the special needs of doctors, staff and their families through eight OSMA-endorsed insurance plans. With OSMA owned and governed Physicians Liability Insurance Company, we offer professional liability and a comprehensive medical/hospitalization plan, PLICO HEALTH. Our other OSMA-endorsed insurance programs are disability income, business overhead expense, term life, accidental death/dismemberment, personal liability umbrella and hospital indemnity.

One of our experienced insurance specialists is available at any time, day or night, to discuss or provide a complete, no obligation, personal and business risk analysis. For more information about our OSMA-endorsed insurance plans, please give us a call.



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# Select Committee on Insurance Rates and Tort Claims: The Work Begins

**T**he Select Committee on Insurance Rates and Tort Claims was established by Oklahoma's new tort reform legislation. It consists of ten legislators and eight lay members and is charged with studying, preparing recommendations on, and drafting legislation addressing the problem of increasing liability premiums and court awards.

Among those testifying before the committee at its September 18 meeting in Lawton were OSMA President Norman L. Dunitz, MD; OSMA Executive Director David Bickham; and C. L. Frates & Company President Rodman Frates. Following are transcripts of their testimony.

## Norman L. Dunitz, MD

Mr Chairman, members of the committee and guests:

My name is Norman Dunitz. I am a practicing orthopedic surgeon from Tulsa, Oklahoma. I am currently serving as president of the Oklahoma State Medical Association and in that capacity represent over 4,000 Oklahoma physicians who provide medical care for the majority of Oklahoma citizens. Mr Chairman, our members are frightened. We are worried about the future of our profession and about the future medical care our patients will be able to receive. We are concerned and worried about the young people in our medical schools today — our future physicians — and we are afraid that the bright young students graduating from our high schools today will not see medicine as an attractive profession for the future.

These fears and concerns are brought about because of a civil justice system run amuck. We are constantly aware that one of our patients might sue us at any time over any incident, regardless of the fact that no medical negligence might have occurred. A lawsuit that will damage my professional reputation would cause untold despair and anguish, and cost an exorbitant amount of money to defend. And if

the court finds me innocent of any wrongdoing, there will be no punishment for the plaintiff and lawyer who brought the action.

Consequently, Mr Chairman and members of the committee, we are costing our patients and the public untold amounts of extra dollars because we are practicing defensive medicine. It is difficult to say how much, but we're talking about lots of money. National estimates range from \$15 billion to \$40 billion each year.

**"Mr Chairman,  
our members are  
frightened."**

Defensive medicine is just one of the byproducts of the professional liability crisis. The availability of medical care is another. A family physician pays about \$1,592 for professional liability coverage, but if he does very much OB, delivering of babies and the care attendant to that, his rate will be \$19,368. As a result, many of our rural physicians are dropping their OB practice. This creates a real hardship for expectant mothers who prefer to get their care from the family physician, not to mention the cost and inconvenience of traveling or the loss of income to the local community hospital.

We are not saying that all doctors are perfect and that malpractice does not occur, and we are not suggesting that the negligent physician be relieved of his responsibility to an injured patient. Doctors have always policed the profes-

sion. There have been peer review committees long before that phrase came in vogue. We have credential committees, tissue committees, infection committees, specialty board exams, in addition to the requirements of the state Board of Medical Examiners. In the last decade we organized the Oklahoma Foundation for Peer Review. All of these groups exist for the purpose of ensuring that doctors are qualified and competent to practice medicine. We can and will identify bad doctors, and we can and will take appropriate disciplinary action. I must say, though, that in recent years we have been hampered by an aggressive federal trade commission and court decisions that construe disciplinary action as restraint of trade.

Another effort of Oklahoma physicians to stabilize and hold down insurance rates was the creation of our own insurance company. Physicians Liability Insurance Company is wholly owned by the medical association. It was funded by assessing all members of the association who have paid an average of about \$2,000 to build its capital and surplus. PLICO writes professional liability coverage for almost all medical doctors in Oklahoma and is run by a physician board. The company started in 1980 and has capital and surplus in excess of \$5 million. PLICO does not make a profit — its basic objective is to collect sufficient premiums to pay legitimate claims and hold down the cost of insurance to physicians and thereby lower medical costs to patients.

PLICO has accomplished its objectives. Physicians in Oklahoma, relatively speaking, have one of the lowest rates in the nation. I mention that because I don't want you to think that this is just a "pocket book" issue. It is true that

**"It's the unfairness  
of the system  
that  
bothers doctors most."**

the costs are high and that the cost of insurance is the fastest-growing part of a physician's practice. It is true that young physicians already saddled with huge education debts often opt to work for large health care corporations that pay the insurance premiums rather than borrow the money for independent practice in a private or rural setting. It is true that some doctors are limiting their practice because of the cost of insurance. But cost is not the only issue — it's the unfairness of the system that bothers doctors most. A civil justice system that permits a plaintiff to file non-meritorious lawsuits against multiple defendants, many of whom were not involved in the patient's care; a system that is so expensive that less than 30 cents of every dollar paid in goes to the injured patient; a system that permits emotional judgments for intangible injuries that exceed amounts that can be paid in two working lifetimes;

## NUMBER OF CLAIMS

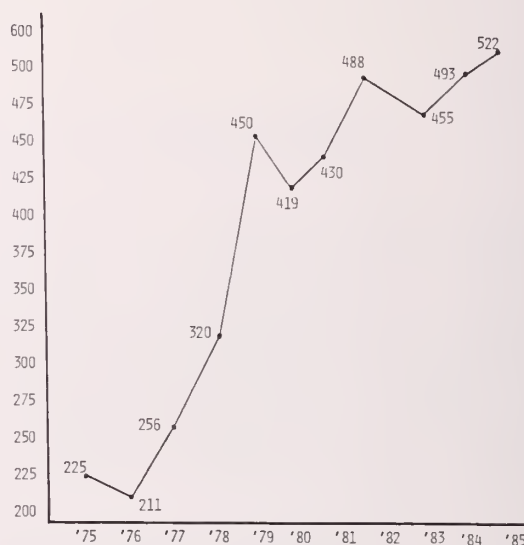


Chart #1

a system that permits double recovery; a system that holds in jeopardy the defendant's assets and professional reputation for 5 to 7 years; and finally, a system that permits the plaintiff's lawyer to become a full partner in the plaintiff's award.

To correct these inequities requires major tort reform. We have and still are giving thought to approaching the legislature with proposals that would help alleviate the problems of professional liability for physicians through legislation that would only apply to torts arising out of medical negligence. This has been done in many states with varying degrees of success. However, it seems to us that the problems caused by the inequities in our civil justice system are sufficiently serious to cause broad scale reform that will apply to all tort actions. So we very likely will continue to work with the coalition "Oklahomans Against Lawsuit Abuse" as they seek tort reform in the coming session.

Mr Chairman and members of the committee, thank you for permitting us to present our testimony. In closing, let me say that the subject you are addressing here today is the single biggest problem our profession faces. It deserves a full public hearing, as you are doing. It deserves the full attention of the Oklahoma legislature, and in our opinion deserves expeditious legislative action.

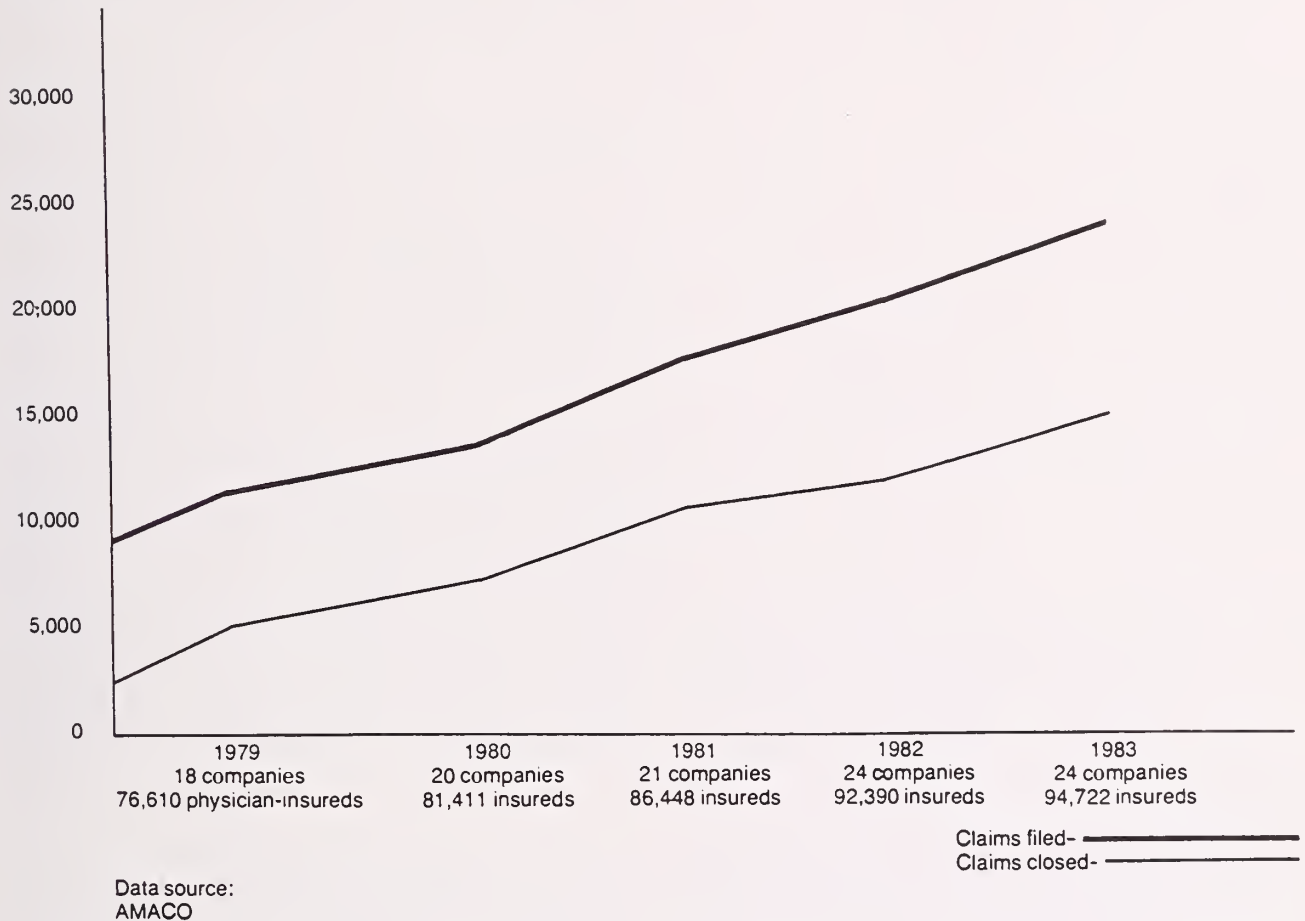
### David Bickham

Mr Chairman, members of the committee:

My name is David Bickham. I am the executive director of the Oklahoma State Medical Association, and I am also the vice president of PLICO — the physician-owned insurance company. PLICO was started in 1980 for the primary purpose of writing professional liability coverage for physician members of the association. PLICO writes two lines of business, professional liability and health insurance. In both lines we restrict coverage to MD physicians, their families, and employees.

## Claims filed and closed : 1979-1983

In recent years the total number of claims filed each year against physician-owned companies has more than doubled. The rate at which claims are closed lags behind the filing rate, leading to a sharp increase in the number of accumulated claims still open. Because of increasing severity of professional liability claims, the longer a claim stays on a company's books, the greater the chances are that it will be more costly to resolve.



Professional Liability Report 2

9

Chart #2

The statistics I will be sharing with you today are on the professional liability line of business, not the health and accident. These numbers represent about 75% of the total experience in the state on medical negligence cases. They do not include the experience of the osteopathic physicians or the 5 to 7% of the state's MD physicians that are not insured by PLICO.

During the course of the debate on the tort reform proposals this past legislative session, we were often challenged about data supporting our position. I hope this information will be helpful to you as you consider this important issue.

Dr Dunitz mentioned in his presentation the business philosophy of PLICO as to profits and premiums. I hope

you'll keep that in mind as we go through this, because some of the numbers will not be as large as some that you've read and heard about in the news. Our doctors are not paying the exorbitant premiums paid in Florida, New York, California, and some other states. There are probably a number of reasons for that. We think our juries are more reasonable, and we probably have a better physician/patient relationship, but if you compare Oklahoma with the national trend, the graphs look about the same, and we may be just a few years behind. In fact, if you compare Oklahoma to the national trend in claims, our experience is a little more drastic than the national picture, and when we compare losses, again we see that our trend is more like the national trend.

## Plico Liability by year

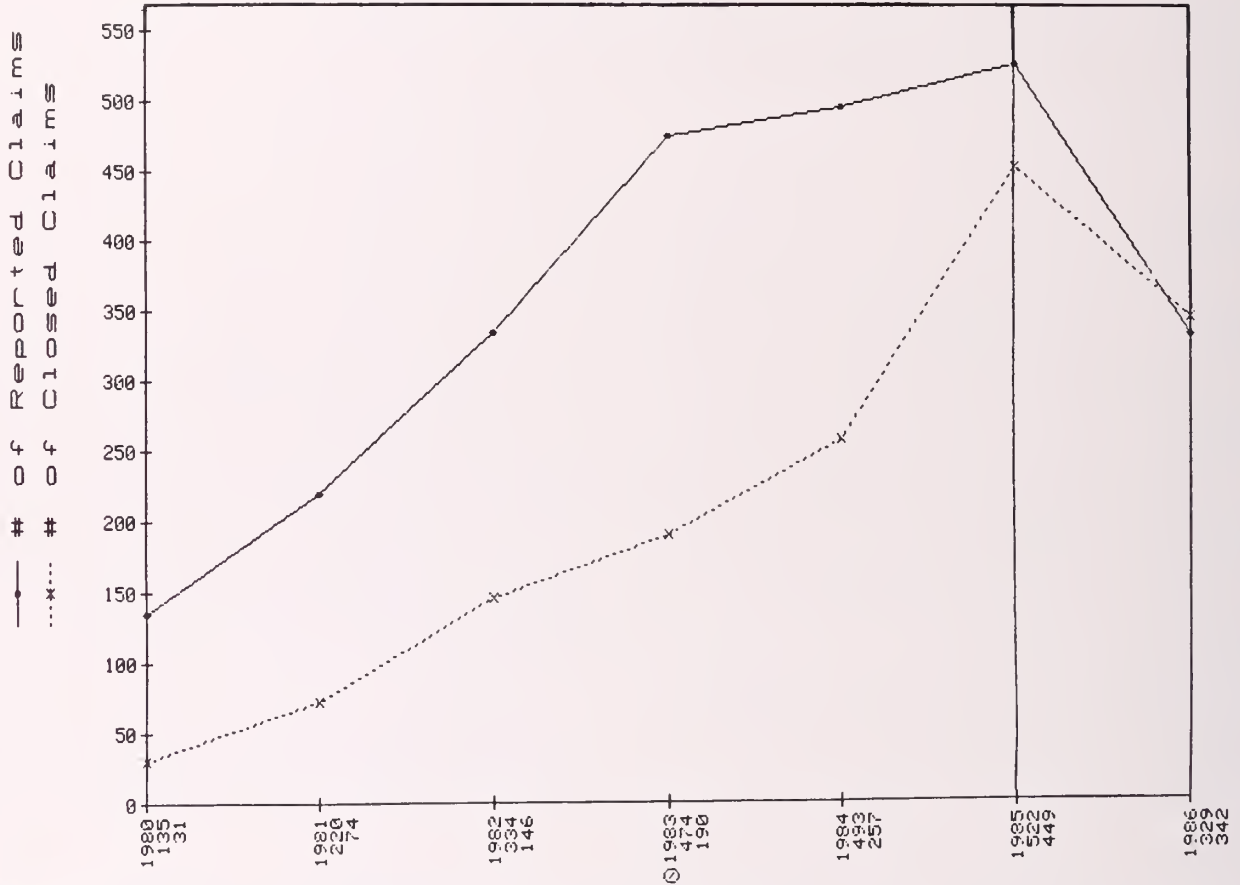


Chart #3

The first graph is a picture of claims activity. As you can see, back in 1975 before PLICO was formed, we were experiencing about 200 claims a year. That number has steadily increased to the current rate of a little over 500 per year—that's an increase of  $2\frac{1}{2}$  times over the decade.

Graphs #2 and #3 compare Oklahoma claims experience with national claims experience and confirm my earlier statement that Oklahoma is not much different from the nation as a whole.

The next chart (#4) is a picture of incurred losses. These are claims that have either been paid or have been reserved for payment. Again the picture is onward and upward, to a point in 1985 that we have paid or expect to pay approximately \$14 to 15 million. I might add at this point that in addition to the known claims there are likely other claims that may be filed in the future—these claims are called incurred but not reported.

So you can see from these two graphs that over the past decade the trend is definitely up, and in the short range since PLICO started, the general trend is still the same.

Chart #5 compares PLICO's experience to the overall Oklahoma experience in general liability. This is one of the charts that Miss Banfield of the ISO offices used in her presentation a few weeks ago. This graphs premium compared to losses related to GNP as you can see. Even though

the picture for general liability is bad, medical malpractice is an even more volatile line of business.

The next chart (#6) explains PLICO's income and expenses. There are only two sources of income—premium and investment income. As you can see, the great bulk of the income comes from the premium directly from the physician's pocket; 16.5% comes from investment income which goes to pay claims and expenses. Lest anyone think we're wizards at investing, that 16.5% is not return on investment but the portion of total income that comes from investments. While all of us were fortunate a few years ago when yields were in 2-digit figures, most of you know that high quality-low risk investments are now yielding on 5 to 6%.

The expense pie shows where the money goes; 73% is paid for claims, etc.

The purpose of these charts is to demonstrate that PLICO's primary objective is to pay legitimate claims. As stated earlier, we don't make profits to distribute to doctors or dividends to policyholders. We run the company as frugally as possible. The physician members of the board are paid a minimum board fee and expenses. They meet bi-monthly.

In summary, Mr Chairman, our statistics support the position that we do have a professional liability problem

in Oklahoma. Claims are escalating, payments are increasing, premiums are rising, and services to patients are being curtailed. Physicians are frightened and are practicing defensive medicine, which drives up medical costs.

We encourage the committee to develop recommendations that will alleviate this situation.

Mr Chairman, that's pretty much the story of PLICO. I would be happy to yield for questions.

## Rodman Frates

Gentlemen:

I have been asked to give you an overview of the insurance problems created by the tort dilemma. Here briefly are the facts:

Currently, one-third of the price of every general aviation aircraft is the cost of products liability insurance. The sales of general aviation aircraft have fallen over the last decade from a high of 27,000 a year to a low of 1,700 in 1985. Much of this decline has been precipitated by the ever increasing costs of the aircraft driven primarily by product liability losses.

In Oklahoma and elsewhere in the United States, many insurance coverages have become totally unavailable, but are still demanded by regulatory bodies like the EPA or the Oklahoma State Health Department. Environmental protection insurance for chemical companies, waste disposal companies, companies involved with nuclear waste and nuclear energy, paper and timber companies, coal mining companies and other mining operations is unavailable. Bonds for many different types of operators including grain elevator operators are now for the most part unavailable. General liability and umbrella liability insurance for virtually all manufacturing risk is now being written on the "claims made" insurance policy. This means that the public

**"Real tort reform  
in Oklahoma  
can bring real jobs and  
real payroll  
to your constituents."**

has no protection if the insured fails to renew his insurance or goes out of business. Furthermore, the policy precludes payment for environmental disease or environmental impairment by exclusion. The cost of this insurance over the last two years has doubled or tripled as the coverage has been reduced.

Municipal governments are unable to buy liability insurance. Hospitals have only one market for liability insurance and that is Hospital Casualty Company. Doctors have only one market for liability insurance and that is Physicians Liability Insurance Company. If they had not formed their own insurance companies, they would have no insurance.

## INCURRED LOSS

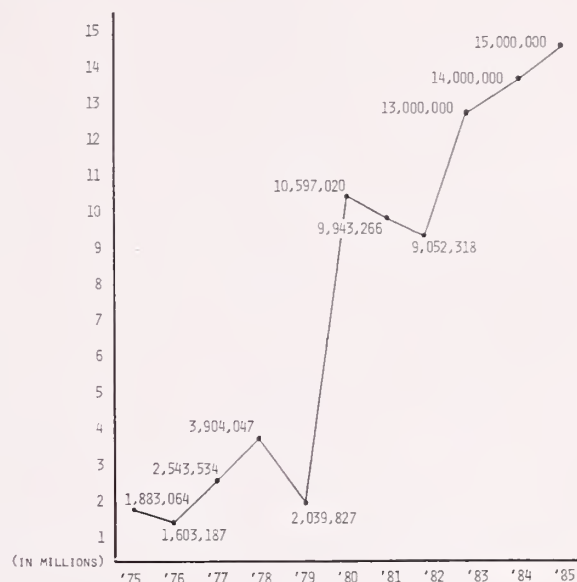


Chart #4

The preponderance of banks in Oklahoma have only one market for their bankers blanket bonds which is required by law and only one market for their directors and officers insurance. They only reason they have that market is because they formed their own insurance company.

Because the "claims made" insurance policy is coming to vogue as a result of disastrous loss experience, the public is not protected by insurance in the way it has become accustomed to being protected. I assure you that as many businesses in Oklahoma fail and leave behind their injured members of the public, your constituents are going to be a legion of unhappy people who say "why the heck didn't government do something about this when they should have."

Let me emphasize that the fault does not lie with your insurance department. Gerald Grimes has done an excellent job in dealing with the problem, but the problem is much bigger than the insurance department's responsibility. This dilemma is not the fault of anybody, but the solution lies in your hands. It has been created by the courts which have been too permissive and by the failure of state and federal government to respond with legislation that will limit the ability of the injured individual to sue and the amount of compensation he may receive. Less than 1% of all the people in the state ever collect a liability claim. Less than 1% of all the people in the state ever sue, yet the excessive amounts of judgments they have collected have cost this state and every citizen of this state hundreds of thousands of jobs and have cost millions in revenue.

The insurance problem is different from the bank problem. There is plenty of demand for insurance, but there is no supply because the legal environment has become so inhospitable. Do not expect help from the insurance marketplace at this time. The great insurance companies are

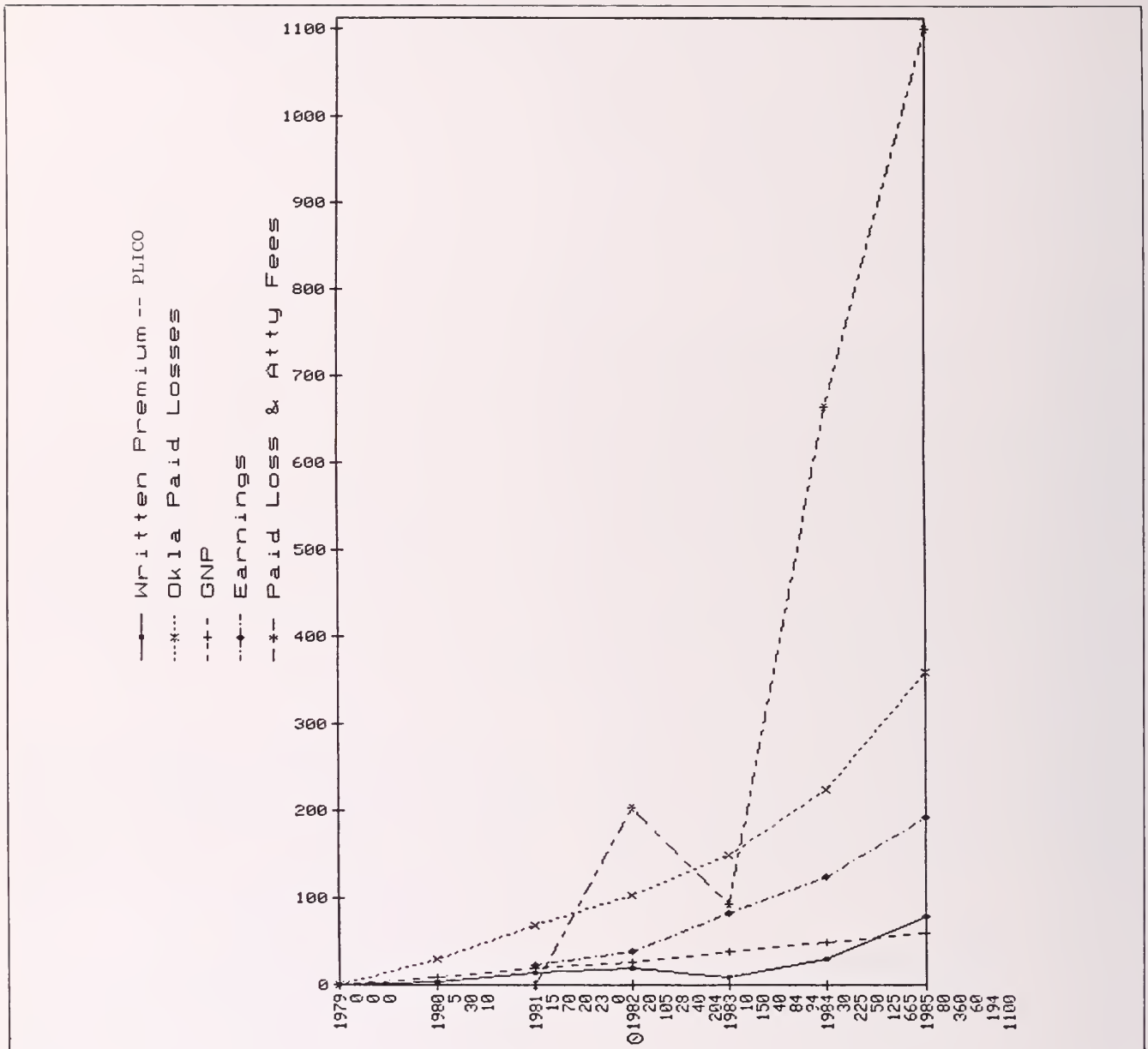


Chart #5

regulated to such a degree that they dare not let their premium volume exceed their surplus by more than 300%. If they should do so, they would be in technical default in the states in which they are domiciled and that includes Oklahoma. Their surplus is already leveraged to the limit. They are not going to help you *unless* you change the laws in such a way that they can write more risk for less premium. The whole public benefits by lower premium and greater insurance availability; only a handful of people benefit by unconscionably high judgments and settlements.

If you want industry to move to Oklahoma, you have to make it good for business to move. If their insurance premiums are lower, they can price their products competitively with foreign products, and they will come here. If their insurance premiums are lower, you are going to make jobs for Oklahomans. We can really help by simply limiting

the size of judgments and eliminating the redundant recoveries by plaintiffs. That is, double collections for the same injury. Sometimes even triple collections for the same injury. Here are more facts:

In the last three years, 61 insurance companies admitted in the state of Oklahoma have gone broke. Nine companies domiciled in the state of Oklahoma have gone broke. Things would have been much worse if you had not had an excellent insurance department. There is only one reason an insurance company goes broke. Investments in Oklahoma are regulated. Insurance companies go broke because claims exceed the loss reserves set up for them. Insurance companies and reinsurance companies going broke nationwide have decreased the capacity for writing insurance in this country by billions of dollars over the last several years. Because of increased losses and the need for increased premiums, the ability of major insurance com-

## PHYSICIANS LIABILITY INSURANCE COMPANY

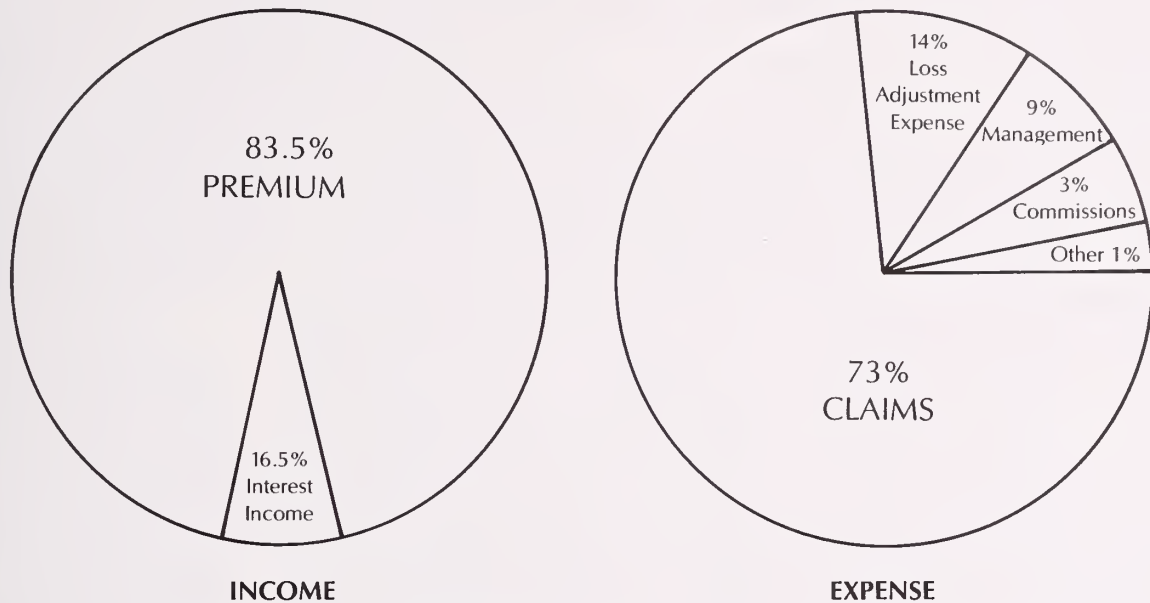


Chart #6

panies to write insurance has been reduced by roughly 50% due to their need to maintain surplus to premium ratios.

These are the facts you are dealing with. No spaceship carrying aliens is going to visit this planet and infuse the insurance industry with additional capital and surplus. The resources are already stretched to the breaking point. No laws that you impose upon the insurance industry will increase their capability to write more insurance. They are like a starving mule lying in the trenches. Whip him and he will die. Give him a drink and something to eat and there is a pretty good prospect that he will continue to pull your load. That drink of water consists of some kind of quick, effective tort reform. Any bill that is less than efficacious is utterly useless, and you can expect as individuals and as custodians of the government purse to see your own

bankroll and that of the state you administer decrease with some rapidity. On the other hand, real tort reform in Oklahoma can bring real jobs and real payroll to your constituents and return the state to prosperity.

If we all want to continue to enjoy the quality of medical care on demand that we have become accustomed to, if we want jobs for the people of this state, if we want to be able to afford goods and services as we have in the past and have enough money in the state coffers to furnish the services the people of the state have come to expect from government, effective and prompt legislation to cure the torts problem is the first and most critical step. The good of the majority has to be considered as paramount over excessive and redundant compensation of a tiny minority.

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*Traditional education system at risk***Cost containment efforts affect clinical training of students**

Competition and cost-containment trends in medicine reportedly are threatening the availability and quality of clinical training for medical students.

Richard L. Egan, MD, secretary of the AMA Council on Medical Education, notes that teaching hospitals, owned or controlled by medical schools, traditionally have provided a variety of clinical experiences for medical students during their third and fourth years. Full-time faculty at these hospitals and at community hospitals used research and clinical investigation to augment teaching opportunities.

"Changes that have already occurred in the role of both the patient and the faculty threaten this system of medical education," Egan concludes in his report in the *Journal of the American Medical Association (JAMA)*. "These changes — past, present, and anticipated — engender pessimism about the survival of an educational system that is based on the study of patients."

Cost containment at the federal level, resulting in diagnosis-related groups (DRGs), has somewhat limited teaching opportunities by reducing the number of patients and shortening hospital stays, Egan observes. "As fewer patients are hospitalized, the population of inpatients may consist primarily of the critically ill. Thus, the medical student would be deprived of the variety of clinical experiences that has been the strength of the clerkship system."

Furthermore, federal support has declined for research and clinical investigation by medical school faculty, notes Egan. "The pursuit of practice income may increasingly occupy the time of the clinical faculty and divert their attention not only from scholarly activities but also from their daily contact with medical students," he says.

Employers' search for less expensive medical coverage has prompted increased competition for patients and spurred the rapid growth of health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Egan predicts that teaching hospitals must become effective competitors in this changing social and economic climate.

"To the extent that the traditional clerkship in a teaching hospital is not feasible, the student and the teacher will have to find new locations where patients are available. Thus, teaching may occur in ambulatory care centers, in HMOs, or in more distant community hospitals," he concludes. □

*Election at Seattle meeting***W. R. Smith, MD, of Enid chosen as ASIM's new president-elect**

William R. Smith, MD, a practicing internist in Enid, has been named president-elect of the American Society of Internal Medicine (ASIM). The election came during the society's 30th Annual Meeting, held September 25-28 in Seattle.

Founded in 1956, ASIM is a federation of state component societies with more than 20,000 members nationwide. Dr Smith will serve on the society's Executive Committee, assuming the office of president in October 1987.

An ASIM trustee since 1982, Dr Smith is a past president of the ASIM/Socio-Economic Research and Education Foundation (SEREF), and continues on SEREF's Board of Trustees. He is a past president of the Oklahoma Society of Internal Medicine, a trustee of the Oklahoma Medical Research Foundation, a past president of the Garfield County Medical Society, and is active in the AMA and OSMA. He is a fellow of the American College of Physicians (ACP).

Dr Smith received both his undergraduate and medical degrees from the University of Oklahoma. Certified by the American Board of Internal Medicine in 1967, and recertified in 1974 and 1980, he is on the staff of Bass Memorial Baptist Hospital and is associate clinical professor of medicine at the University of Oklahoma. □





The OSMA Board of Trustees held their fall meeting on September 7. Michael J. Haugh, MD, Tulsa, (left) former chairman of the board, receives a plaque of appreciation from



his successor, Thomas N. Lynn, Jr., MD, Oklahoma City. At right, Donald G. Kassebaum, MD, new dean of the University of Oklahoma College of Medicine, addresses the group.

### Women's response differs from men's

## Female alcoholics may need different type of treatment

Women respond to alcohol differently than men do, and their reasons for abusing alcohol as well as their desire for treatment of alcoholism may differ also, according to a recent report.

The findings point to the need for alcoholism prevention and treatment programs tailored to women's needs, according to the review article by Sheila B. Blume, MD, of the State University of New York at Stony Brook and South Oaks Hospital, Amityville. She notes, in the *Journal of the American Medical Association (JAMA)*, that most of what is known about alcoholism is based on studies of male alcoholics, but that recent studies are beginning to focus on women.

"The cohort of women born in the 1950s may be showing a higher rate of heavy and frequent drinking than the generations of women who preceded them," Blume says, adding that the risk of alcoholism in the current generation of women approximates that of men in their fathers' generation.

Compared to men, women show different psychological responses to alcohol, according to the report. Women have much more variability in day-to-day peak blood alcohol levels, related in part to the menstrual cycle, with highest peaks during the premenstrual phase. Studies have even noted differences between men and women in perceived versus measurable sexual arousal, related to alcohol use. Women who abuse alcohol also have the potential of causing permanent damage to their offspring (fetal alcohol syndrome) if they drink during pregnancy.

## September Life Members from Tulsa, Ponca City, Shawnee

Four Life Memberships were approved by the Oklahoma State Medical Association's Board of Trustees at their September 7 meeting.

The new Life Members are Dixon N. Burns, MD, and Allen B. Eddington, MD, Tulsa; E. Edwin Fair, MD, Ponca City; and John R. Hayes, MD, Shawnee.

To be eligible for a Life Membership, an OSMA member must meet one or more of the following qualifications: (1) Be retired from the active practice of medicine due to age or ill health, (2) Be engaged in the active practice of medicine for fifty years or more; (3) Be seventy years of age or older. □

Other studies have shown that, even after accounting for differences in body weight, alcohol-included diseases develop in women more quickly than in men.

These may include liver damage, fatty liver, hypertension, obesity, anemia, malnutrition, and gastrointestinal hemorrhage.

"Women suffering from alcoholism experience a high rate of mortality, both when compared with the general population of women and when compared with alcoholic men," Blume says. Although women generally begin alcohol abuse at a later age than do men, male and female alcoholics seek treatment at about the same age, she observes, "a finding that suggests a more rapid development or telescoping of the course of the illness in women."

Alcoholic women are more likely than alcoholic men to associate the onset of problem drinking with

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On a recent visit to Oklahoma City, Gilde Breidenbach (ctr), health legislative assistant to Oklahoma Congressman Dave McCurdy, reviewed congressional health proposals with OSMA Executive Director David Bickham (left) and Associate Director Robert W. Baker III.

## Female alcoholics (continued)

a particularly stressful event, Blume says. "Their motivations to enter treatment and the problems they perceive relating to alcohol are more likely to be health and family problems, whereas for the male, job and legal problems, particularly arrests for driving while intoxicated, are more prevalent," she observes. "Her findings suggest the need for treatment programs designed especially for women.

The best predictor for problem drinking among women, according to a 28-year follow-up study of college students, was the use of alcohol to relieve shyness, or to otherwise help in social situations, Blume notes.

"These findings indicate that prevention efforts should focus not only on those young people who have already developed alcohol problems, but also on those who drink to enhance their ability to function," she concludes. 

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## Study looks at prepaid OB-GYN care

### "Routine care" varies, even within same medical group

A survey of medical groups providing prenatal and gynecological care finds considerable disagreement among clinicians as to what should constitute "routine" care.

The study, by Michael J. Hughey, MD, of the Northwestern University School of Medicine, Chicago, indicates that in actual clinical practice, "many providers of care don't adhere to routines recommended by textbooks, professional groups or legal precedent," and this leads to the diversity in "routine" care.

Hughey's study, published in the *Journal of the American Medical Association (JAMA)*, involved information provided by 26 prepaid medical groups throughout the US that represented nearly 1.7 million members and performed nearly 26,000 deliveries annually. Each group was questioned about assorted tests, protocols for frequency of visits, and routine clinical care provided.

For obstetrical patients, all or most groups offered a number of routine tests and assessments per prenatal visit or at least once during pregnancy, the study found. These included maternal weight, blood pressure, urinalysis, blood count, Rh testing, Pap smear, Doppler monitoring of fetal heart rate, childbirth education, and amniocentesis in older women.

However, the study notes wide variation in other types of services offered. For example, 21% of the groups routinely offered an ultrasound scan despite the conclusions of a National Institutes of Health Consensus Panel that "the data . . . do not allow a recommendation for routine screening at this time."

"Perhaps the routinely scanned patients are the fortunate few who are seeing enlightened physicians. Perhaps they are victims of obstetricians who are too quick to recommend new, inadequately tested procedures," the study says.

The report also notes that only 11% of pregnant women were offered serum alpha-fetoprotein screening to detect neural tube defects, but that "does not mean that those who offer it are wrong and should stop offering the test." Similarly, the fact that 92% of pregnant women were offered Doppler ultrasound evaluation of the fetal heart at each prenatal visit "does not mean that those using the Doppler are right to do so and should continue."

## "Routine care" (continued)

Variation also was found in the "routine" care of gynecological patients. Less than half the groups offered annual urinalysis and less than a third offered an annual complete blood count. Two-thirds offered menopausal counseling and estrogen therapy to menopausal women, but only one-quarter to one-half routinely asked about diet, exercise, smoking and alcohol habits, and sexual issues.

While acknowledging the study's limitations, including the possibility that the respondents might not be truly representative of prepaid group practice or might have incomplete knowledge of their group's routine practice habits, "some fundamental truths are demonstrated" by the survey, Hughey says.

"Those purists who believe they have found the 'right' methods of delivering routine prenatal and gynecologic care should note that in many cases, substantial numbers of practitioners will disagree with them," he says. "Those physicians who are uncertain of the best approach to routine care should be pleased to find the diversity of clinical practice demonstrated here."



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## Ethical guidelines proposed for AIDS antibody screening

Universal mandatory screening for human immunodeficiency virus (HIV) [also known as HTLV-III] antibodies is not appropriate, according to a report from the Hastings Center, published in the *Journal of the American Medical Association (JAMA)*. Such screening can be justified only when a therapeutic intervention is available or when an infectious state puts others at risk through casual contact, and neither is the case with AIDS, the report adds.

The Hastings report supports continued mandatory screening of all donated blood, as well as voluntary screening by members of high-risk groups. It outlines rare situations in which mandatory screening or a breach of confidentiality may be justified, and proposes ethical guidelines to be used in evaluating screening programs.

Ronald Bayer, PhD, and colleagues, of the Hastings Center, Hastings-on-Hudson, NY, say all screening programs should be evaluated according to ethical principles based on respect for people, the harm principle, beneficence, and justice. Among their recommendations: the purpose of the screening must be ethically acceptable, and its means and intended use must be appropriate to the purpose; persons must be notified that screening will take place, and should be informed about the results; sensitive and supportive counseling programs must be available to inter-

pret results, and confidentiality must be protected.

"The most important potential benefit of the knowledge of a positive test result to an individual is the motivation to change behavior that puts others at risk," the researchers say, adding that appropriate legislation or administrative regulations should be designed to protect confidentiality of test results. Only in rare cases would public health reasons justify a breach of confidentiality; for example, if a seropositive individual were found to have recently donated blood, the blood collection agency should be told immediately.

"Under no circumstances should test results be used in ways that bear no relationship to legitimate public health concerns," the report warns, adding that the only employment situations in which mandatory screening might be justified are prostitution or health care involving the treatment of open wounds.

The researchers describe the military's routine HIV screening of all recruits and active duty personnel as "troubling" because other reasons may be concealed under the guise of public health. Policies against homosexuality and drug use, foreign governments' concerns about exportation of AIDS, and desire to avoid the economic burden of AIDS should be addressed directly, they say, not masked as public health issues.

Finally, the report suggests that persons at high risk for developing AIDS have a moral obligation to take all possible steps to prevent harm to others, and this includes voluntarily taking the antibody test. "Public health authorities and clinicians should actively encourage the use of such tests, to be taken anonymously or with strict confidentiality protections," the report says. □



Attending the meeting of the OSMA Board of Trustees in September are Richard L. Winters, MD, Poteau (left), and Thomas J. Lowrey, MD, Yukon. On the right, behind Dr Lowrey, is David A. Ronk, MD, Norman.

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## DEATHS

### John Douglass Jennings, MD 1925 - 1986

General practitioner John D. Jennings, MD, died May 12, 1986, in Duncan. Dr Jennings, a native of Wynnewood, was a World War II veteran, having served with the US Army field artillery in the European Theatre. He earned his medical degree in 1954 at the University of Oklahoma and established his private practice in Hugo the following year. He moved to Duncan in 1962.

### Welborn Ward Sanger, MD 1906 - 1986

OSMA Life Member Welborn W. (Buck) Sanger, MD, died in Oklahoma City September 19, 1986. The ophthalmologist was a 1931 graduate of the University of Oklahoma School of Medicine. During World War II he served as a reserve officer for five years, retiring as a lieutenant colonel. He then returned to Oklahoma City, where he practiced until his retirement in 1978. Dr Sanger was a diplomate of the American Board of Ophthalmology and a member of the American College of Surgeons. He was also a faculty member at the OU medical school.

### Marcella Reed Steel, MD 1905 - 1986

Dr Marcella Steel Ruprecht, an anesthesiologist, died in Tulsa October 1. Dr Steel, as she was known professionally, was a Life Member of the OSMA. Born in Mankato, Minn, she earned her medical degree at the University of Wisconsin in 1930 and moved to Tulsa in 1933. She and her husband, cardiologist Homer A. Ruprecht, MD, were named "Doctors of the Year" by the Tulsa County Medical Society Auxiliary in 1975.

**December 1  
is the closing date for  
the January 1987 JOURNAL.**

## IN MEMORIAM

### 1985

<i>Meredith M. Appleton, MD</i>	<i>September 7</i>
<i>Robert A. Northrup, MD</i>	<i>September 8</i>
<i>Carl H. Bailey, MD</i>	<i>September 9</i>
<i>Hugh B. Spencer, MD</i>	<i>September 13</i>
<i>Bernice E. McCain, MD</i>	<i>September 14</i>
<i>Robert E. Campbell, MD</i>	<i>September 23</i>
<i>Minard F. Jacobs, MD</i>	<i>September 30</i>
<i>Robert Ray Rupp, MD</i>	<i>October 2</i>
<i>William C. Moore, MD</i>	<i>October 24</i>
<i>Michael Wayne Durbin, MD</i>	<i>November 13</i>
<i>Alan Luis Gorena, Jr., MD</i>	<i>November 19</i>
<i>William Hampton Garnier, MD</i>	<i>November 20</i>
<i>Jesse Ray Waltrip, MD</i>	<i>November 30</i>
<i>Charles F. Obermann, MD</i>	<i>December 30</i>

### 1986

<i>Alexander Poston, MD</i>	<i>January 3</i>
<i>Francis M. Duffy, MD</i>	<i>February 5</i>
<i>Edward L. Leonard, MD</i>	<i>February 14</i>
<i>William C. Tisdal, MD</i>	<i>February 24</i>
<i>Donovan Dillon Mosher, MD</i>	<i>April 4</i>
<i>Fred D. Switzer, MD</i>	<i>May 10</i>
<i>John D. Jennings, MD</i>	<i>May 12</i>
<i>Phillip Wade Jones, MD</i>	<i>May 18</i>
<i>Herbert L. Owen, MD</i>	<i>May 28</i>
<i>Marianne Elsbeth Kosbab, MD</i>	<i>June 13</i>
<i>William W. Rucks, Jr., MD</i>	<i>June 27</i>
<i>Ralph A. Smith, MD</i>	<i>July 27</i>
<i>Howard D. Tuttle, MD</i>	<i>August 3</i>
<i>Welborn W. Sanger, MD</i>	<i>September 19</i>
<i>Marcella Steel, MD</i>	<i>October 1</i>

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## BOOK SHOP

**Epidemiology of Anencephalus and Spina Bifida.** By J. Mark Elwood and J. Harold Elwood. New York, etc: Oxford University Press, 1980, pp 413, illustrated, price not given.

Physicians and other workers in the British Isles and in Canada have long devoted extensive attention to the severe, distressing, and related congenital malformations, anencephalus and spina bifida. They represent two of the most common major congenital malformations of the central nervous system occurring in developed countries at the present time. Dr Mark Elwood, head of the division of epidemiology of the cancer control agency of British Columbia, and Dr Harold Elwood, professor of social and preventive medicine at the Queen's University of Belfast, have joined to produce a comprehensive analysis of all epidemiologic aspects of these anomalies. It consists of thirteen chapters plus appendices. It begins with a review of the history of these disorders and proceeds from the pre-Christian era to present-day attitudes and knowledge towards these abnormalities. The anatomic and epidemiologic features of the topic are concisely but thoroughly considered. The chapter which reviews brown teratogenic agents is particularly well done. Chapter 13, on directions for further research, is excellent. Its encyclopedic nature is apparent from the 1,200 references which it contains.

This book is an essential reference in the libraries of epidemiologists, and the several different medical and related disciplines that deal with children with spina bifida.

*Harris D. Riley, Jr., MD  
Oklahoma City*

**The Social Transformation of American Medicine.** By Paul Starr. New York: Basic Books, Inc., Publishers, 1982, pp 514, \$24.95.

This book represents one of the most ambitious and comprehensive analyses of American medicine to appear in some time. Paul Starr, a sociologist, describes the evolution of American medicine from a chiefly domestic affair into "a vast industry." Although the chief emphasis is on social and economic aspects, he also includes a large amount of information dealing with other aspects of medicine in his analysis.

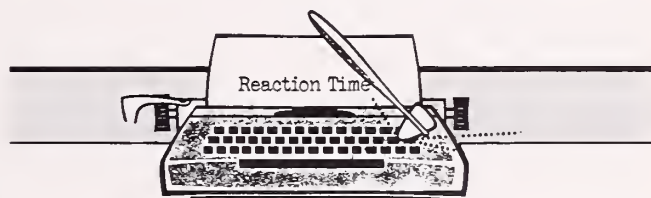
As pointed out in the preface, this history is divided into two books to emphasize two "long movements" in the development of American medicine: first, the rise of professional sovereignty; and second, the transformation of medicine into an industry and the increasing role of corporations in the state. Book one consists of

six chapters which take the reader through 1930, and book two comprises five chapters. Within the framework of the two books, Starr explores a variety of pertinent and specific questions which are fundamental to knowledge of the development of medicine in this country.

One of the engaging features of this book is the author's ability to take a complex situation, analyze it, and identify specific patterns. For example, he provides an excellent analysis of the discrepancy between value of service and fee charged — for instance, between certain nonsurgical and surgical specialists — and identifies many of the factors which have allowed this unhealthy situation to develop.

Starr believes that the continued independence of the medical profession will be diminished for a variety of reasons. This is one of the most important analyses of medicine to be published in recent years.

*Harris D. Riley, Jr., MD  
Oklahoma City*



## Reader encourages editor to adopt more positive outlook

*To the Editor:* I was much impressed with the editorial ["The New Doctor"] from the *JAMA*, August 22-29. Although I understand the level of frustration that often leads to the editorials we read in the *JOURNAL*, this is a perspective that I believe should be adequately shared with the membership of the Oklahoma State Medical Association. It is easy to be negative in these days; it is much harder to be positive.

Food for thought.

*William G. Thurman, MD  
President  
Oklahoma Medical Research Foundation  
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*Being negative is not all that easy. The really hard part is finding out what's going on.*

—Ed.

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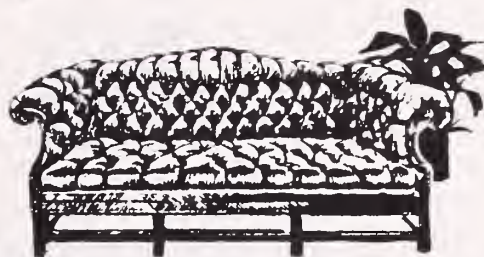
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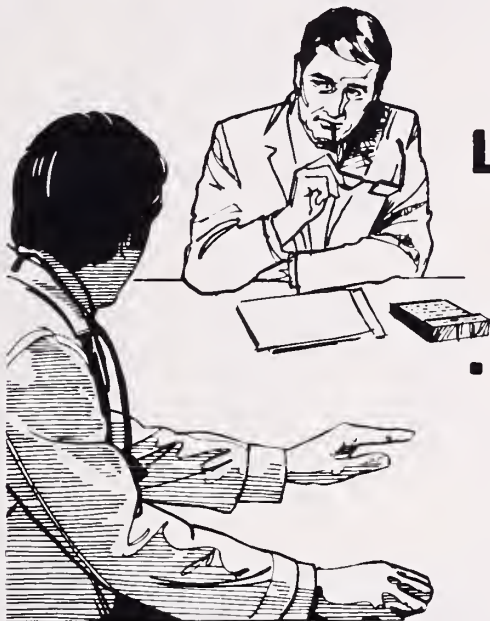
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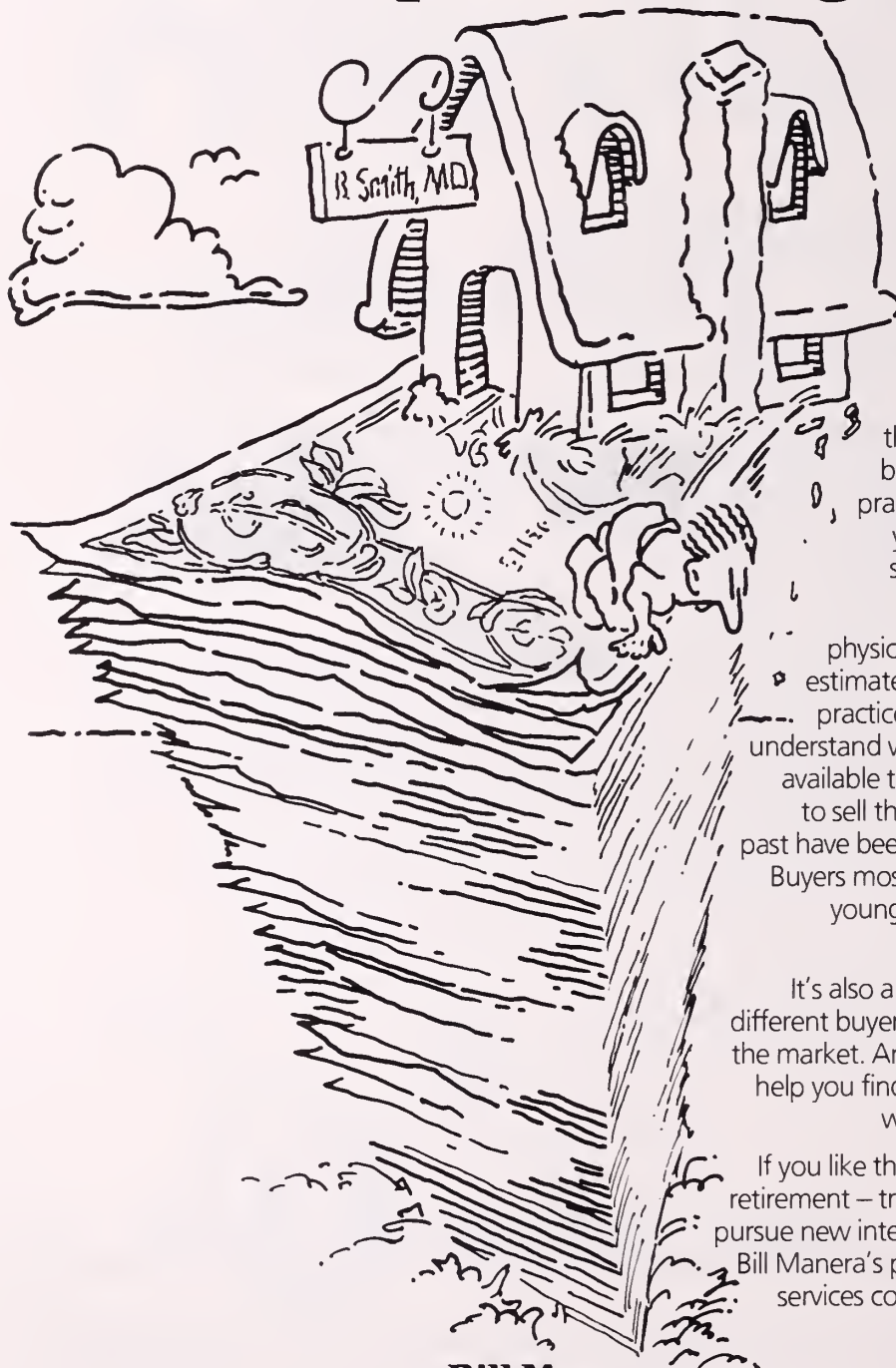


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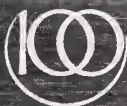
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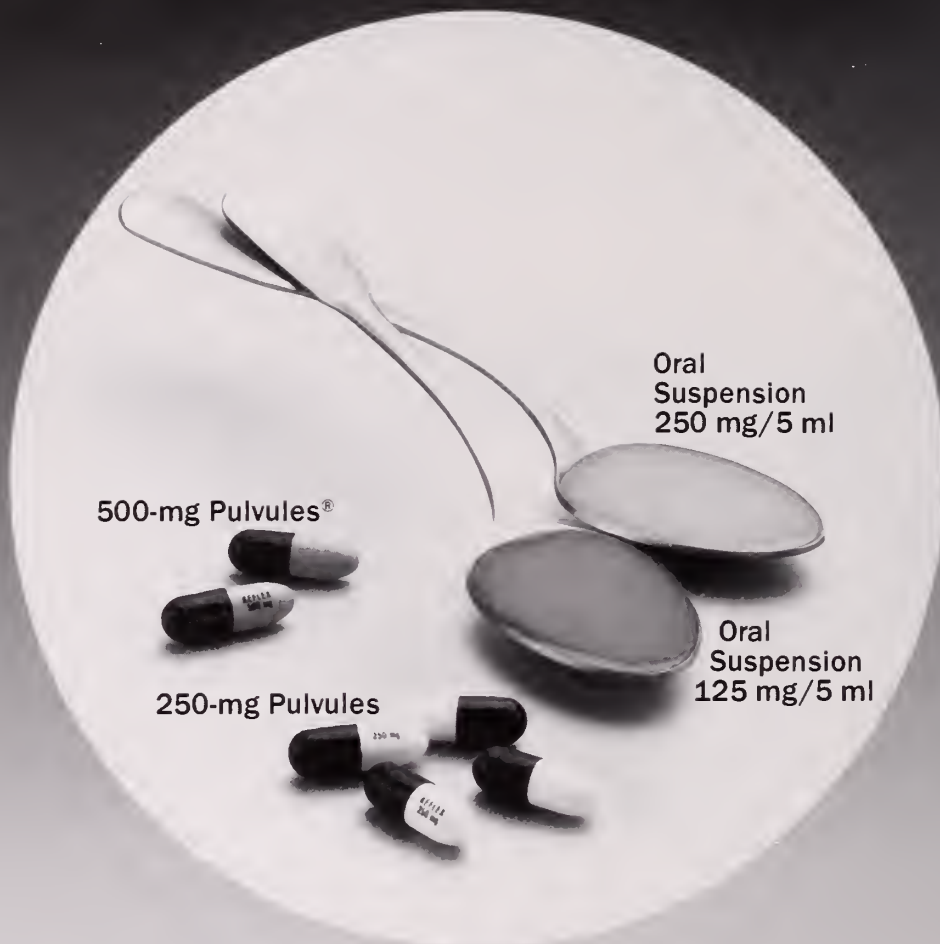
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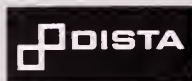
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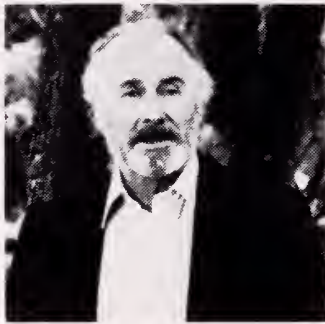
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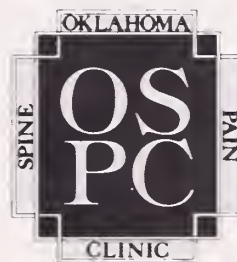
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## **"Instead of worrying about the future let us labor to create it"**

— H. Humphrey

Such sentiment has never been more applicable to the medical community. The spacial as well as social, economic, and political environment in which medicine is practiced today and in which we, our families, and our neighbors receive and provide health care is unprecedented! The byproducts of the changes are varied — some are positive, some are negative. Among the positive are, in some cases, cost-effective care, among the negative the utter confusion and bureaucracy created for physicians, other health care providers, and patients.

Similarly under the new medical regulations the quality of care for the elderly is judged to be deteriorating. Data recently released by the Health Care Financing Administration (HCFA) were interpreted by many including Senator John Heinz (R-PA) to be detrimental to the aged. The amount and kind of financing available for medicare is forcing many health care organizations to close their doors.

Medicare HMOs were the panaceas as early as last year; yet many are closing their doors. Maxicare in Illinois and in Cincinnati are exemplary as is United Health Care in Minneapolis. Stories of the patients who may be our parents, families, and friends being denied sufficient length of stay in hospitals permeates. We too will be classified as elderly — some sooner, some later.

Recent studies predict that by 1990 physician satisfaction with his/her profession will be lower, his/her standard of living will be lower, but his/her training longer. They will see fewer patients but will be more involved in paper work.

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There are many needs and every one of them is important. Let us meet your needs and help us meet medicine's. If the Oklahoma State Medical Association Auxiliary is to be responsive to your needs as well as to the community's it must have your support, your ideas, your participation, and your membership. Together we can nourish this organization to become more responsive and ever more effective.

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## THE LAST WORD

■ **The 1987 OSMA Annual Meeting has been moved.** Oklahoma City's Sheraton-Century Hotel will be the location of the meeting scheduled for May 1-3. Originally set for Shangri-La Resort on Grand Lake, the meeting was moved to Oklahoma City to accommodate a new meeting format. Current planning calls for the Opening Session of the OSMA House of Delegates to be held on Friday, May 1, and the Closing Session to be held on Sunday, May 3. The Sheraton-Century Hotel is located in downtown Oklahoma City.

■ **Wednesday, February 18, 1987, is the date set for OSMA Medicine Day at the state capitol.** A joint project of the OSMA and the OSMA Auxiliary, Medicine Day is intended to demonstrate to legislators the interest of Oklahoma's physicians in the state's legislative process as it relates to the medical profession. Details about Medicine Day will become available this winter.

■ **Biopsy of the thymus performed at the same time as open lung biopsy can help physicians distinguish AIDS from certain types of congenital immunodeficiency syndromes in children,** according to a report in the *Archives of Pathology and Laboratory Medicine*. V. V. Joshi, MD, of the Children's Hospital of New Jersey-United Hospitals Medical Center, Newark, and colleagues performed 11 such biopsies on children with AIDS. They report various anatomic and histologic changes in the thymus tissue. Thymic biopsy also improves "understanding the earlier stages of AIDS in children and its possible progression," the researchers add.

■ **Training family members to perform cardiopulmonary resuscitation (CPR) may lead to increased anxiety among heart patients at home,** according to a report in the *Archives of Internal Medicine*. Kathleen Dracup, RN, of UCLA, and colleagues randomly assigned family members of cardiac patients to one of three groups: CPR training, risk factor education, or control. The study found no adverse effects of training on family members (mostly wives of patients). "The patients in the CPR group, however, were more anxious at three months' follow-up than patients in either the educational or control groups," says the researchers. "Patients in both CPR and risk factor education groups reported poorer adjustment to illness at six months' follow-up than did control patients." Citing the obvious benefits of CPR training, the researchers conclude that it should be presented in a manner that minimizes stress.

■ **Two research groups writing in the *American Journal of Diseases of Children* report encouraging results of studies comparing a conventional diphtheria-tetanus-pertussis (DTP) vaccine with a new DTP vaccine using an acellular, or partially purified, pertussis component.** The studies, by researchers at the Vanderbilt University School of Medicine and UCLA School of Medicine, involved a total of 100 children aged 18 to 24 months and 40 children aged 4 to 6 years. Both reports compared an acellular pertussis component vaccine, developed for use in Japan, with the standard, whole-cell pertussis component type. Antibody response to both vaccines was comparable, but the acellular variety caused far fewer reactions, such as fever, redness, tenderness, swelling, fretfulness, and vomiting. Both studies cautioned, however, that additional trials are needed to fully evaluate the efficacy of the acellular vaccine.

■ **Indomethacin, a nonsteroidal anti-inflammatory agent, seems to reverse or decrease an immunologic defect that commonly occurs after major trauma or surgery,** according to a report in the *Archives of Surgery*. Thomas S. Kupper, MD, of the Yale University School of Medicine, and colleagues, say that of 19 patients, 11 demonstrated depressed response of peripheral blood mononuclear cells to phytohemagglutinin, five to seven days after surgery. Eight of the patients developed infectious complications, the report notes. "The addition of indomethacin to in vitro cultures resulted in an average enhancement of the PHA response to 37% of baseline," the researchers say. They caution, however, that more studies are needed to define the risks and benefits of the drug before it can be used for this purpose in patients.

■ **The number of general surgical operations in the US has increased minimally over the last five years but the number of general surgeons has grown steadily,** according to a report in the *Archives of Surgery*. Ira M. Rutkow, MD, MPH, of the University of Medicine and Dentistry of New Jersey and the Freehold Area Hospital, Freehold, NJ, says data from the National Center for Health Statistics show a 7% increase in general surgical operations from 1979 to 1984. During the same period, however, there was a 13% increase in the number of general surgeons, he says. If this trend continues, Rutkow warns, the result could be a decrease in individual operative workloads and a possible adverse effect on the quality of general surgical care. □

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